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ABSTRACT

The fourth volume in a 10-volume report on the historical development (1966-1973) of the 8 administrative Area Offices of the Indian Health Service (IHS) Mental Health Programs, this report presents information on the Albuquerque Area Office. Included in this report are: (1) The Context (geographic distribution; IHS facilities; population served; and culture of the American Indians served--Pueblo, Ute, Jicarilla Apache, and Mescalero Apache); (2) Introduction of Mental Health Services (personnel for 1967, 1968, and 1969 summer); (3) Expansion and Development of Mental Health Programs (continuation of the Northern Section; tensions between two psychiatrists, administration from 1970 to the present, hiring mental health coordinators from 1970 to the present, the 1971 clinical psychologist and the development of St. Catherine's School Project and other activities at Laguna and Acoma); (4) Rounding Out Program Development (contract care in the mental health program with emphasis on inpatient and alcoholism services and the children's program, 1972 to present staff completion, special interest in alcoholism program developments, and current Jemez and Mescalero developments); (5) General Observations (description of staff consultation activities, 1974 change of command, problems, and accomplishments). (JC)

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Vol. 4, Set 1

ED133108

ALBUQUERQUE AREA

Service Networks
and
Patterns of Utilization

Mental Health Programs I.H.S.
Partial fulfillment of
Contract No. 103-73-342

U.S. DEPARTMENT OF HEALTH
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ALBUQUERQUE AREA

MENTAL HEALTH PROGRAMS

OF THE

INDIAN HEALTH SERVICE

1967-1973

1975

IHS Contract No. IHS HSM 110-73-342

A documentary narrative in partial fulfillment of contract entitled:

Service Networks and Patterns of Utilization
Mental Health Programs
Indian Health Services

Prepared by

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This material has been prepared in connection with an initial evaluation contract to appraise IHS Mental Health Programs seven years after their formal introduction into the system in 1966. (IHS Contract No. HSM 110-73-342) As originally conceived the report was to be based upon a sampling of about three programs in the eight major Areas: One outstanding, one average, and one new or otherwise struggling. Administratively, Area Chiefs of Mental Health and their staffs found it impossible to participate in such a selection, and instead the staff has been required to inform themselves about over 90 programs and present their findings about each as objectively as possible.

The chapter for each Area follows a standard arrangement of information, varying in detail as the Area development indicates. There is first a description of the geographic and cultural context within which Area programs and Service Units work. Secondly, there is a reporting of the historical roots of mental health activities in the Area as far back in time as it has been possible to find evidence of them. In some instances this is coincidental with the formation of IHS in 1955, but in most it appears a few years before introduction of formal budgetted mental health staff. The latter sections of the report develop in chronological order (usually in two year segments) the personnel and activity of the Mental Health programs for the Area. Unique and special programs are presented in detail. Finally, an overview and summary of achievements and problems yet to be resolved concludes the description of the Area, which was completed as of the spring of 1973.

The concluding chapter of the report and the extensive sections on inpatient programs will be of interest to all Areas. It is also hoped that staff in one Area will find it of value to see what other Areas have done or are facing in the way of similar problems, and differing ones. However, when need arises, or interest is focused on only one Area, it is hoped that that chapter may be used as an independent unit.

ALBUQUERQUE AREA IHS MENTAL HEALTH PROGRAMS

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S T A F F

Wm. Davis, M.D.		July 1967 - May 1974 (tnsfrd to another area)
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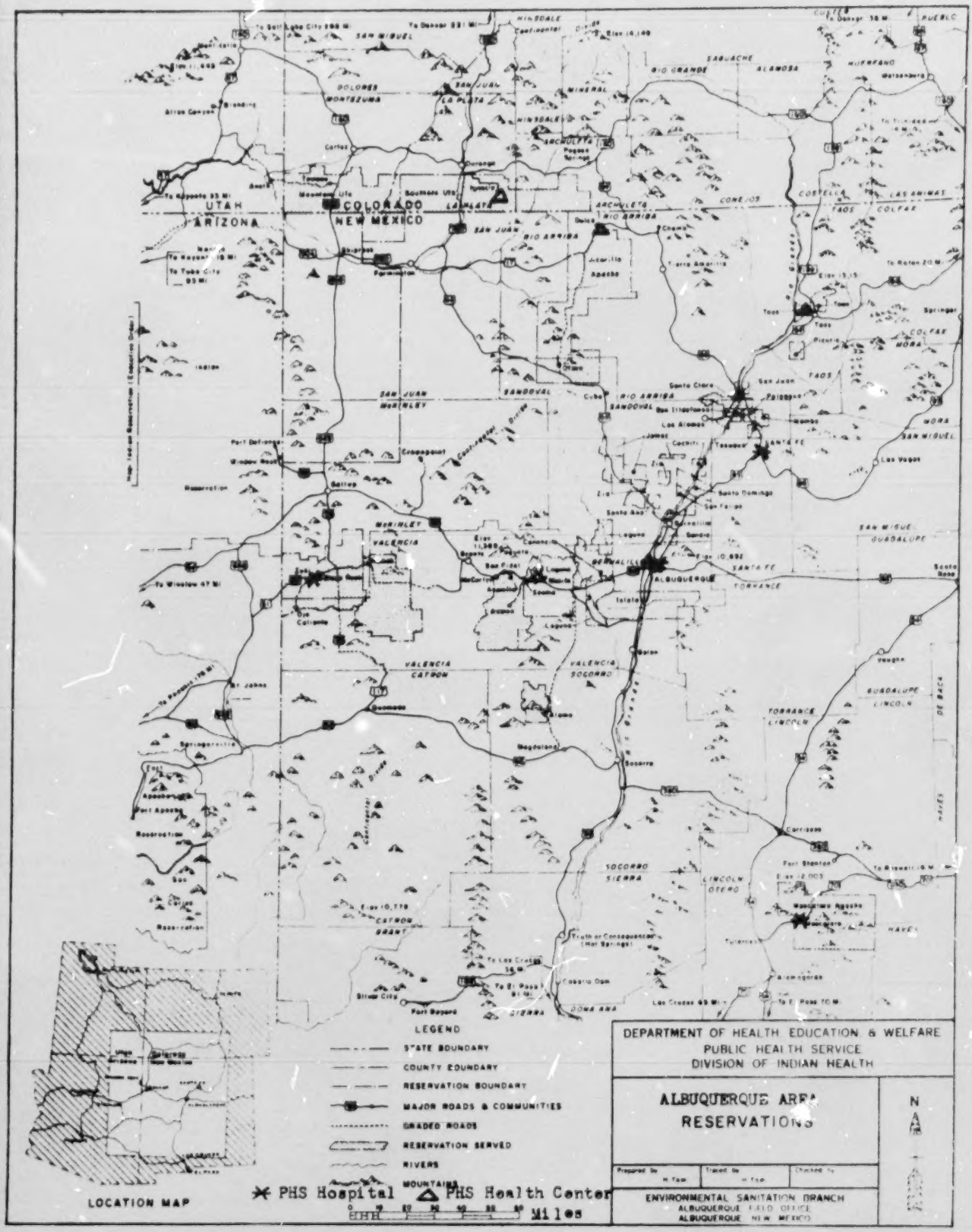
A. Padilla	(Santa Clara)	July 1972 - present
A. Archuleta	(San Juan)	July 1972 - present
D. Dodd		July 1972 - present
F. Chavez	(Santo Domingo)	July 1974 - Aug. 1974 (resigned to take another job)
B. Jaramillo	(Isleta)	July 1974 - present
J. Ellis, M.D.		July 1974 - present


UTAH
COLORADO
NEW MEXICO
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ALBUQUERQUE
SANTA FE
LEGEND
STATE BOUNDARY
COUNTY BOUNDARY
RESERVATION BOUNDARY
MAJOR ROADS & COMMUNITIES
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LOCATION MAP
DEPARTMENT OF HEALTH EDUCATION & WELFARE
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DIVISION OF INDIAN HEALTH
ALBUQUERQUE AREA
RESERVATIONS
ENVIRONMENTAL SANITATION BRANCH
ALBUQUERQUE FIELD OFFICE
ALBUQUERQUE NEW MEXICO

ALBUQUERQUE IHS AREA MENTAL HEALTH PROGRAMS 1967-1974

I. THE CONTEXT

A. Geographic Distribution

On the maps of IHS, the Albuquerque Area is outlined as the two states of New Mexico and Colorado, except for that portion of the Navajo Reservation that lies along the northwest border with Arizona. However, the actual distribution of Indian populations served within these two states is much more concentrated. While there may be sizeable urban populations of Indians in Denver and other Colorado cities, these are not taken into consideration as yet by IHS. The only Indian reservations in Colorado are in the extreme southwestern section, known as the "Four Corners Region". Here, along the western slope of the San Juan Range of the Rockies, and westward onto the Colorado Plateau into Utah are two reservations for the Ute Indians. The closest large center of population and commerce is Durango, Colorado with Cortez as a second available town. A landmark in the vicinity is Mesa Verde National Monument, an ancient cliff dwelling.

In New Mexico, the Indian populations served are mainly concentrated in the northwestern quadrant of the state. Nineteen pueblos lie along the Rio Grande River and its tributaries, and form the bulk of the populations served. These pueblos and their culture will be described in detail in a section to follow. They can be found on a geographical map by locating Taos in the edge of the Canadian Rockies at the northern center of the state. Starting from Taos, and following the Rio Grande southward, one finds the Pueblos lie along it, or its tributaries the Jemez and the Puerco Rivers,

as far south as Isleta, below Albuquerque. The westerly extensions of the pueblos follow the same contours of old river beds and high mesas that were used by the railroads and highway developers (Interstate 40, formerly Route 66).

At the extreme west, lie Zuni Pueblo, and its neighboring pocket of Navajo at Ramah Reservation. Acoma, Laguna, and two small Navajo communities, Alamo and Canoncito, make the chain that reaches between Zuni, eastward to Albuquerque and the Rio Grande. North of Albuquerque are Jemez, Zia, and the old village of Santa Anna. Cochiti, Santo Domingo, San Felipe, Sandia and the New Village of Santa Ana lie along the Rio Grande between Albuquerque and Santa Fe. In the northern valley of the Rio Grande San Juan, Santa Clara, San Ildefonso, Pojoaque, Nambe, Tesuque, Taos and Picuris comprise the 8 northern pueblos. The only other Indian population for which the Albuquerque Area provides services is the Apache, who are remote from any other Indian group in the state. The Mescalero Reservation is located in the Rocky Mountains north of El Paso, Texas, near the resort communities of Cloudcroft and Ruidoso. Diagonally across the northwest is the Jicarilla Apache Reservation with Dulce as its main community.

The BIA has a number of boarding schools in New Mexico. These schools in Albuquerque and Santa Fe receive services from the Mental Health Program, to the extent that they can be absorbed by the system. The BIA school at Magdelena has received semi-regular services since very early in the program. Its location, south of the main pueblo population, made it difficult to reach easily.

Thus, although perhaps including some of the most fascinating cultures, and beautiful wooded mountains, canyons and mesas of the state, not all of the

Land of Enchantment is involved in the thinking and planning of the IHS programs in the Albuquerque Area.

B. IHS Facilities

There are only four IHS hospitals in the entire Albuquerque Area. Mescalero IHS Hospital, of 15 beds and built in 1968, is the most modern of these structures. It has stereo piped-in music, and an inviting atmosphere. It serves only the Mescalero Reservation, and Area IHS Mental Health staff visit at least twice monthly.

The Zuni Hospital of 42 beds is a complete general hospital and cares for all except highly specialized needs of the Zuni, the Navajo at Ramah, and other residents of the far western reaches of the Area, mainly those Navajo who find it easier to reach than Crown Point or Gallup. Zuni Service Unit operates a Field Health Station for the Ramah Reservation for outpatient services on a regular part-time schedule.

Residents of the rest of the Area must use either Albuquerque or Santa Fe Hospital or arrange for contract services. The pueblos in the central part of the state are generally served by Albuquerque, from a hospital which has been increasingly converted to general medical and surgical uses since 1969. Before the 70's it was almost entirely utilized as a Tuberculosis Sanitarium, and some TB cases are still seen here and cared for in a special wing. Field Health Clinics are located at Jemez, Zia, Santa Ana, Sandia and Isleta and Canoncito. These provide outpatient, dental, environmental, and other services on a part-time basis. A Health Center at Laguna operates almost as an independent Service Unit, and also maintains a Field Health Station and dental program at Acoma. A contract with Bernallilo County Medical Center in Albuquerque provides for a large proportion of the hospital needs

A

PROVISIONAL ESTIMATES OF "SERVICE POPULATION" BY AREA OFFICE, SERVICE UNIT AND AGE GROUP*
ALBUQUERQUE INDIAN HEALTH AREA OFFICE
June 30, 1968

AGE GROUP	Albuquerque Area Office TOTAL	Albuquerque (H.C.)	Con-Ute	Jicarilla	Laguna	Mescalero	Santa Fe	Taos	Zuni-Ramah
ALL AGES	27,600	5,750	1,600	1,600	5,750	1,400	4,600	1,700	5,200
Under 1 year	1,030	220	60	60	220	50	170	60	190
1 - 4	4,070	850	240	240	850	210	680	250	770
5 - 9	3,920	820	220	220	820	200	650	240	740
10 - 14	3,480	730	200	200	730	180	580	210	660
15 - 19	2,700	560	160	160	560	140	450	170	510
20 - 24	2,180	450	130	130	450	110	360	140	410
25 - 29	1,660	350	100	100	350	80	280	100	310
30 - 34	1,480	310	90	90	310	80	250	90	280
35 - 39	1,140	230	60	60	230	50	190	70	210
40 - 44	1,160	240	70	70	240	60	200	80	220
45 - 49	1,160	240	70	70	240	60	190	70	220
50 - 54	860	180	50	50	180	40	140	50	160
55 - 59	870	180	50	50	180	40	140	50	170
60 - 64	590	120	30	30	120	30	100	40	110
65 - 69	410	90	20	20	90	20	70	30	80
70 - 74	400	80	20	20	80	20	70	20	70
75 and Over	490	100	30	30	100	30	80	30	90

* Service Unit totals may not add to Area Office total because of rounding.

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B

NEW MEXICO POPULATION, 1970 CENSUS

COUNTIES

County	1970		1960	
	Indian	Total	Indian	Total
New Mexico State	72,788	1,016,000	56,255	951,023
Bernalillo	5,839	315,774	3,378	262,199
Catron	10	2,198	37	2,773
Chaves	603	43,335	116	57,649
Colfax	45	12,170	15	13,806
Curry	116	39,517	22	32,691
De Baca	2	2,547	-	2,991
Dona Ana	207	69,773	67	59,948
Eddy	83	41,119	39	50,783
Grant	84	22,030	10	18,700
Guadalupe	-	4,969	1	5,610
Harding	7	1,348	-	1,874
Hidalgo	20	4,734	-	4,961
Lea	175	49,554	44	53,429
Lincoln	82	7,560	45	7,744
Los Alamos	71	15,198	42	13,037
Luna	9	11,706	1	9,839
McKinley	26,507	43,208	21,104	37,209
Mora	2	4,673	-	6,028
Otero	1,620	41,097	1,195	36,976
Quay	18	10,903	4	12,279
Rio Arriba	2,755	25,170	2,349	24,193
Roosevelt	97	16,479	10	16,198
Sandoval	6,796	17,492	5,941	14,201
San Juan	18,439	52,517	14,212	53,306
San Miguel	91	21,951	39	23,468
Santa Fe	1,096	53,756	842	44,970
Sierra	16	7,189	42	6,409
Socorro	707	9,763	619	10,168
Taos	1,193	17,516	980	15,934
Torrance	7	5,290	4	6,497
Union	11	4,925	2	6,068
Valencia	6,080	40,539	5,095	39,085

"-" means zero.

April 1971
Bureau of Indian Affairs
Statistics Division

of the populations served by these field stations.

At Santa Fe, another 45 bed hospital, serves all the northern pueblos, the Jicarilla Apache and the Ute Reservations. Public Health and Field Health teams are active among the pueblos within range of Santa Fe, holding regular clinics at San Felipe, Santo Domingo, San Juan and Santa Clara. Health Centers at Taos, Dulce (Jicarilla) and Ignacio (Mountain Ute) Reservations are maintained to provide outpatient care. Contract services with facilities in Durango, Colorado and other more local resources are often handier than the hospital in Santa Fe, and are used by these remote Health Centers for emergencies when transportation to an IHS hospital would pose problems.

C. Population Served

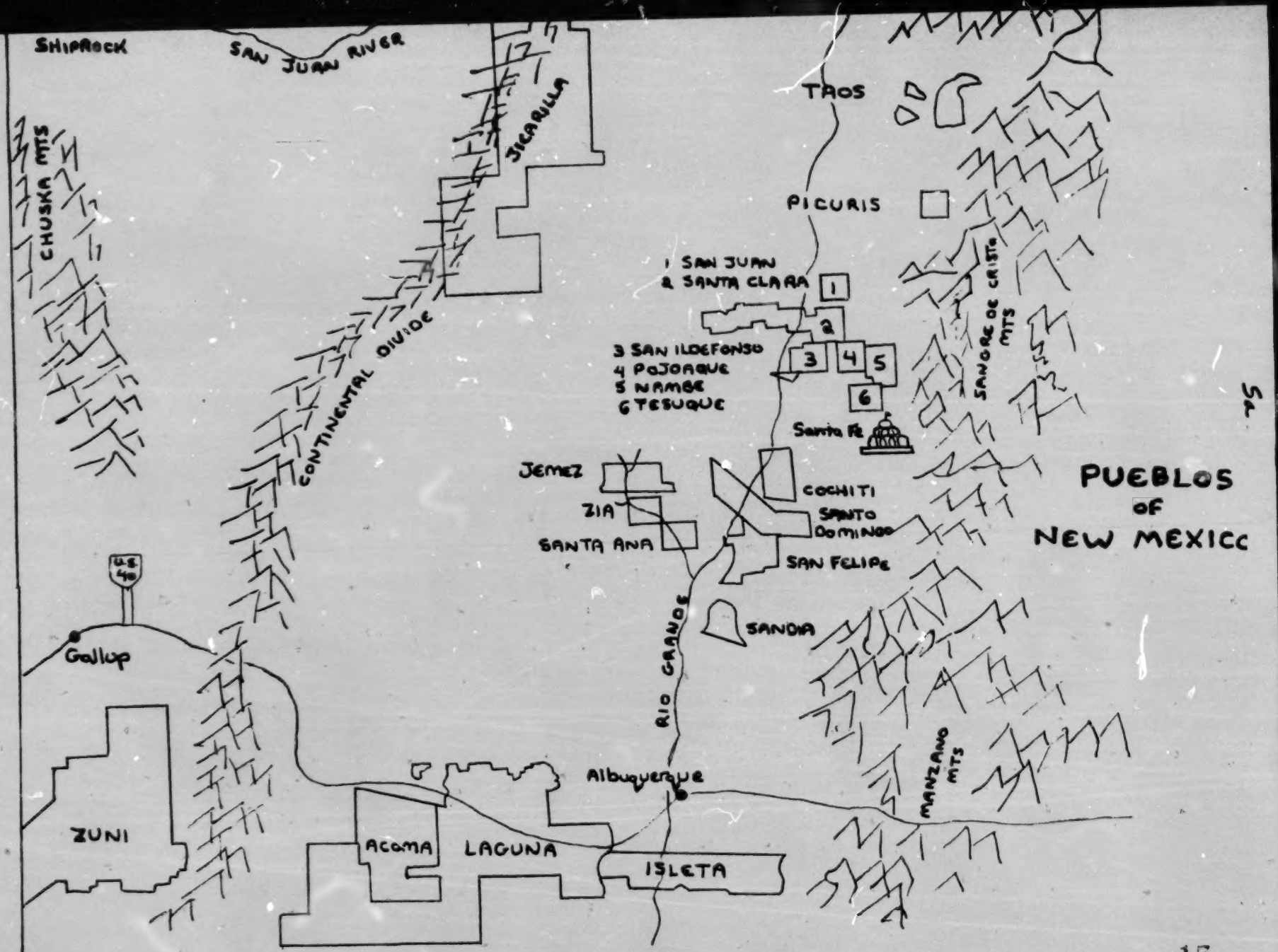
The table that follows, shows the distribution of populations served by each of these Service Units, according to data prepared in 1968 (Table A). The Indian population is on the whole a youthful one, as can be seen from Table A, with 70% being under the age of 30.

Although the total Indian population served by the Albuquerque Area is given as seven percent by the US Census (Table B), both BIA and IHS staff estimate that this is at least a 10% underestimate, and that by 1970 the population being served was approximately 30,000. While only a tiny fraction of the Colorado population is involved, the groups served by the Albuquerque Area make up approximately 5% of the New Mexico population, and a far larger percentage of those counties where they reside. The pueblos in Sandoval County, together with the Navajo communities there, represent 39% of the population, according to 1970 census figures. McKinley County, which includes the Zuni Reservation, shows that 61% of the population is Indian. Taos County has a 6% Indian pop-

ulation. Rio Arriba County, which includes the bulk of the Jicarilla Apache Reservation has an 11% Indian population. Valencia County, which includes the Ramah, Acoma, and Laguna Pueblos, has 15% Indian population. Bernalillo County, where Albuquerque is located, and Santa Fe County, with the State Capitol, show smaller percentages because of the concentration of metropolitan populations in these major cities. The attached summaries of the 1960 and 1970 Census show a total of 7% Indian population for the state as a whole, but some of this is due to the Navajo Reservation which does not come under the responsibility of the Albuquerque Area of IHS. (See Table B.) What is significant is the steady increase estimated by IHS as about 1.7% overall. Due to the youthfulness of the Indian population, the number of persons for whom services are to be provided is expected to increase over the next decade.

D. The Cultures of the Indian Populations Serviced

One generalization can be made about the Indian populations served by Albuquerque IHS Area: For the most part, these Indians are still living mainly where they have always lived since contact with white European civilization. This is certainly true of the Pueblos, who received rights to their lands and the privileges of retaining their formal governmental structures from the Spanish. These treaties were later ratified or accepted by the Mexican and US governments in succession, so that there has been no major formal interruption of these elements of the culture. There has been some shrinkage of lands claimed, and also some recently restored as for instance the return of Blue Lake and its access to the Taos Pueblo in the early 1970's. There


SHIPROCK
SAN JUAN RIVER
CHUSKA MTS
JICARILLA
CONTINENTAL DIVIDE
TAOS
PICURIS
1 SAN JUAN
2 SANTA CLARA
3 SAN ILDEFONSO
4 POJOAQUE
5 NAMBE
6 TESUQUE
SANGRE DE CRISTO MTS
Santa Fe
JEMEZ
ZIA
SANTA ANA
COCHITI
SANTO DOMINGO
SAN FELIPE
SANDIA
RIO GRANDE
PUEBLOS OF NEW MEXICO
US 66
Gallup
ZUNI
ACOMA
LAGUNA
ISLETA
Albuquerque
MANZANO MTS

has been only one episode of violent rebellion on the part of the pueblos. Pope's Rebellion was a coordinated attack on the Spanish settlers in about 1680. A Fiesta in Santa Fe in August is considered by most persons to mark the reconquest by the Spanish in 1696. However, many Indians still enjoy the Fiesta as a covert celebration of the Pueblo victory.

The Mescalero Apache groups were confined, but not displaced from portions of their original hunting ranges. This seems also to be true of the two Ute tribes, who have had mainly friendly relationships with the US since the late 1800's. The Jicarilla Apache originally ranged to the east of Taos, but were displaced to similar land west of the northern Rio Grande. The Navajo, and to some extent the Apache, have some bitter memories of Kit Carson's implacable campaigns, but on the whole, Indian and non-Indian relationships have been ones of co-existence.

But other than this, it is difficult to generalize with any sense of accuracy or credibility over the more than 25 tribal and cultural units for whom services must be designed. The basic divisions of Pueblo, Apache, and Ute need some description, but differentiations within each of these may be as important in developing rapport and designing services as distinctions between the major groups.

1. Pueblo

a. Pueblo Cultural Characteristics

The pueblos have dominated the imagination of travellers to the Southwest since the first explorers. Coronado in his search for the fabulous Seven Cities of Gold was directed eventually to the Rio Grande Valley, where he found villages ("pueblos" in Spanish) of peoples living in stone or adobe houses and

multiple dwellings not unlike apartment houses of several stories. By many standards these were wealthy people having a complex and well-organized community structure, stores of farm produce and craftsmen's products, and stable relationships with one another. The wealth was not in gold and precious stones sought by the Conquistadores, however, and there are still many chuckles as Indian people tell their versions of this will o' the wisp quest.

Anthropologists have speculated over the link between the Pueblo culture of today and the abandoned cliff dwellings that can be-seen at Mesa Verde, Canyon De Chelly and Bandelier National Parks and Monuments. Famine, attacking nomads, or a population explosion affected these more ancient communities somewhere between 1000 and 1300. By the time of the Spanish explorations, the pueblos had been established in the valleys and on the mesas as free-standing communities, although similarities to the cliff dwellings in the construction and organization of living quarters can be traced, as well as evidence of Kiva-based religious/political activity. Both stone and adobe bricks are used in construction of pueblo villages with cottonwood or willow roof supports.

The compact social, religious and political organization around the village itself is a salient characteristic of the Pueblo cultural type. Each village is a complete unit, equated politically to a tribe in other Areas, since it is so self-contained. Newcomers often mistake the generic term "Pueblo Indians" for a tribal designation, instead of realizing that 19 pueblos means 19 tribes.

The key to the interaction of each pueblo's culture probably lies in the intertwined religious and political life of the community. Religious practice centers in the Kivas, of which each pueblo has at least two (except for Laguna). The Kiva itself is a meeting place for the men of the pueblo, and in tradition was often underground, although more modern Kivas may be built above the ground.

The Caciques, or Senior Leaders of the Kiva instruct the young and carry out the initiation and other rituals essential to the life of the people. Traditionally, they also designated a "Governor" and council for each pueblo. The "Governor" became the legally recognized official for conducting federal and other tribal business. This post carried with it a religious obligation of service to the pueblo, and selection is not an election in the usual democratic sense. After the Reorganization Act of 1934, a number of pueblos* moved to a constitutional form of government, with general participation in the election of officials. Traditions remain strong even with this modern innovation.

Since the days of the Spanish explorations, Mission churches have been built adjacent to the pueblos, although seldom permitted entirely within the settlement. Over the years migrants have sometimes developed a town or village structure with new dwellings and shops that make it appear that the Catholic Church rather than the Kiva is the central focal point of the community. However, most of the Pueblo people participate in activities of both, so that over the years the celebration of Saint's Days and the rites of the Pueblo religious observances have merged in many instances. The figures of the saints may be paraded and the dancing of the processional practiced in the Kiva without internal contradictions being felt by the participants.

This layering of culture is sometimes so intertwined that it is impossible to separate the pure strands, while in other instances they are clearly separated in space, with representation of the civil and mercantile aspects of the US culture visible as a separate strand in the life of the pueblo. Taos, the northernmost of the pueblos, provides the most easily seen example.

*Zuni, Laguna, Isleta, Santa Clara, San Ildefonso, Pojoaque, Nambe and Tesuque.

The Taos Pueblo itself, one of the oldest continuously inhabited multiple-family dwellings in the whole of the Americas, centers around a large, five story, terraced building, located along a clear running stream about four miles from the town of Taos. Not all the members of the pueblo live here, since the reservation includes many acres, stretching back into the mountains, to the recently restored sacred Blue Lake. However, the majority of the Taos Indians are located in the near vicinity, and are governed by the traditional system of Caciques.

Three miles away is the community of the modern town of Taos. This was originally a trading post along one of the roads derived from the Santa-Fe Trail which passes to the east across the Sangre De Cristo Mountains and joins the Cimmaron Canyon that leads down to the grazing ranges of the High Plains. The high mountains provided vistas and clearness of air that appealed to the artists and writers of the early 1900's, and by 1920 Taos was well-known as an artists' colony. It still flourishes in this capacity today, with many studios, galleries and shops where craftsmen, painters and sculptors show their skills, and sell to both the serious collector and the tourist. Tourism, until the last few years, was a seasonal industry, flourishing in the summer months. However, the development of nearby ski areas is turning this aspect of Taos life into a year-round activity.

Approximately five miles south of the town of Taos is found the Mission church, Rancho De Taos, which has been restored and is still in use. It displays a miraculous painting and artifacts relating to the Spanish period of New Mexico's history, as well as providing religious services for the Roman

Catholics of the region. A smaller church is also to be found on the Taos Reservation itself, with considerable Indian adaptation in its furnishings and liturgy.

The BIA school and IHS Health Center are located within a mile of the Pueblo, but are not integrated into it.

The ruling councils and Governors of the Taos Pueblo have been most conservative about allowing modern inventions and changes within their precincts. Visitors and strangers are politely but firmly excluded between sundown and sunrise. Sight seeing tour busses must turn off their public address systems upon entering the bounds of the Reservation. Recently there have been serious debates in the governing council about the advisability of utilizing such modern and "foreign" devices as electricity and plumbing systems within the Pueblo itself.

However, unlike conservative Taos where strands of development have been kept pure, some of the other Pueblos do not have such spatially visible five mile differentiation of the periods of their development. In San Juan and Pojoaque the communities intermingle in a single town. The Pueblos, 'Anglo', and Spanish populations and their associated stores, courts, churches, schools and other institutions are not isolated from one another. However, the Pueblo people are usually located within the housing clustered around the original Pueblo, and ownership of lands by the community will largely follow ratified Spanish land grants.

b. Grouping of Pueblo's by Linguistic Characteristics

There are a number of possible arrangements or subdivisions of the 19 Pueblos served by IHS from the Albuquerque Area IHS Office. Scholars frequently organize the pueblos into several clusters according to the linguistic characteristics of their culture. It is of interest to note that in spite of overtly similar arranements of governing bodies, housing, and social customs, there are several distinct language families spoken. Indeed, inhabitants of neighboring pueblos must use English or Spanish to communicate in some instances, since not only the dialect, but the root languages in use are not at all related.

The largest language grouping is the Tanoan, which subdivides into Tewa, Tiwa (or Tigua as it is sometimes written), and the distinct language of the Jemez Pueblo. Tewa is spoken by the pueblos of Nambe, Pojaque, San Ildefonso, San Juan, Santa Clara, and Tesuque, all located fairly close to Santa Fe. This grouping is used by the IHS Mental Health Program for assigning one of its professional consultants, even though he has not made mastery of the language one of his goals. It is for him simply a convenient geographical grouping. Tewa is spoken in one of the Hopi pueblos and is the only pueblo language used outside New Mexico.

The related but still distinct Tiwa language base is used in the pueblos of Isleta and Sandia near Albuquerque, and in Taos and Picuris at the far northern end of the Rio Grande Valley. Isleta often competes with St. Augustine in Florida for title to the oldest settlement in the United States, but perhaps because trade and travel routes have not

capitalized upon its location, it is not as well preserved or as well known away from the Southwest.

The Jemez Pueblo, located northeast of Albuquerque on the Jemez River, has a distinct language of its own within the Tanoan family. The Zuni language, unrelated to any of the others, is also unique to its population, and is unrelated to the three major linguistic families.

The second large language family spoken in the pueblos is Keresan. It is known only in New Mexico, and used by the pueblos located mainly in the central and western portions of the state: Acoma, Laguna, Santa Ana, Zia, Cochiti, San Felipe and Santa Domingo.

c. Social Action Political Groupings

In the past ten years these six pueblos located in Sandoval County have organized themselves into a united grouping for many purposes; Sandia, Santa Ana, Cochiti, Zia, San Felipe and Jemez. Starting originally as an effective way to develop community action programs on a larger base than any one pueblo, they were known as SSCIPCAP(Skipcap)— Six Sandoval County Indian Pueblo Community Action Programs. As the funding base has shifted for these programs, the pueblos organization is moving toward an incorporated status in order to negotiate not only federal grants but also contracts for industrial and other purposes. Santa Domingo, also in Sandoval County, has not joined in this united effort.

A similar group, though not organized along language family lines, is the Eight Northern Pueblo organization which has its main headquarters in San Juan north of Santa Fe, and which includes San Juan, Santa Clara, San Ildefonso, Pojoaque, Nambe, Taos, Tesuque, and Picuris. This group has

been effective in developing an alcoholism program, which utilizes a number of resources of industrial and economic needs in its rehabilitation program. It is also becoming an effective lobbying and political action grouping.

d. IHS Relationships to the Pueblos

Of the 19 pueblos served by IHS then, 14 are organized into these two groupings for social action purposes. Santo Domingo, Laguna and Zuni are the largest independent pueblos. Isleta is geographically south of the others, while Acoma has always struggled between a desire for splendid isolation and a need for outside assisting resources. In addition, an all Pueblo Health Advisory Board has been formed to aid in developing IHS policy.

Perhaps the only comparable relationships between IHS or other federal agencies and local Indian and native groups is found in Alaska, where the Eskimo villages, rather than a "tribe" constitute the political unit to which IHS relates. In some ways the difficulties of the Albuquerque Area in relating to its 'catchment area' may be subtly related to this contrasting way of thinking about social and cultural units that characterizes federal policy. The Pueblos as such do not think of themselves as tribes, in the usual accepted sense of the word. They are each distinct and unique communities -- in some cases composed of more than one village (Laguna for instance is an organization of five villages). Each has its own governance, usually based on both religious and political roles within the community, and each has been able over the centuries of contact with outsiders to maintain its own body of social, religious and language characteristics, while maintaing mainly peaceful relationships.

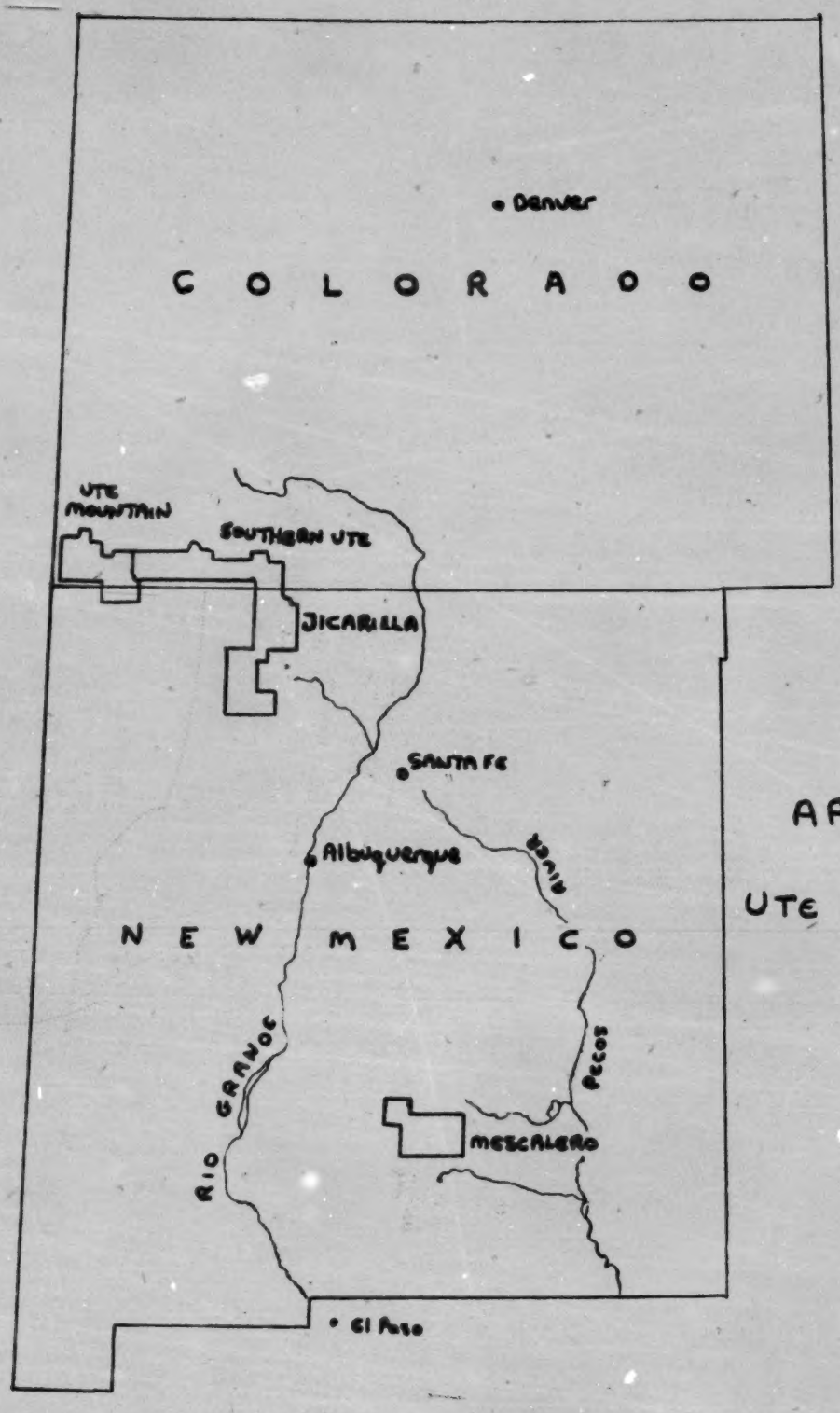
One of the keys to the perpetuation of the culture, and to its maintenance as a separate community, lies in the deeply-rooted tendency of each pueblo to impose a taboo on the discussion of its religious practices and value systems with outsiders of any description. Organized around a men's religious society, known as the Kiva after its usual meeting place in a special chamber, often partially or wholly under ground, this religiously-based system selects the Governor of the pueblo, and the various official representatives. Both the Spanish and US have incorporated recognition of this system. The BIA permits both methods of designating tribal officials.

In the past when outsiders have either been given open access to the meetings, as in the days of the Spanish Missions, or penetrated its inner circles as did some of the 19th Century and early 20th Century anthropologists, the information revealed was used to subjugate, destroy or exploit the Pueblo by Spanish, Mexican and US officials and settlers. Therefore, somewhat naturally reserved people have learned from bitter experience that the sacred and unspeakable are not to be discussed lightly, and probably not at all except among members of the particular pueblo. The use of a separate language, unknown to outsiders and not translated even by bi-lingual pueblo dwellers, protects this core of inner belief and practice.

This makes for difficulties for Mental Health professionals who are trained in middle class American society, and who, no matter how well-meaning their efforts to understand may be, often find access to the information about the sources of personal distress blocked. This hurdle is not insurmountable, but it is a difficult one. One of the professional consultants in the Albuquerque Mental Health Program describes his position thusly: "When I arrived I felt as though I was at least a mile in distance from the center of the life of these people. After a year I am only one foot closer."

Acceptance by, and familiarity with one pueblo does not mean a generalizable acceptance in others. Although the cooperative arrangements have been mentioned, and although there are commonalities described at an abstract level by anthropologists, the local and specific loyalties and familial as well as cultural bonds are to the individual pueblo, and not to a generalized cultural group. This can often pose problems for the children of inter-pueblo marriages. If one parent of such a union dies, the children may be left in a kind of limbo since one of the pueblos may use lineage relationships tangential or antithetical to the remaining parent. The results are somewhat parallel at times to the fates of children born to Vietnamese women fathered by the American and European armed forces members -- disowned by both countries and virtually stateless.

At the same time, the populations of the pueblos are almost all English speaking, with a high rate of bi-lingualism and tri-lingual members, since Spanish is also a Lingua Franca in New Mexico. There is great variability in literacy and the utilization of technical skills, but generally speaking the Pueblo Indian group can and does participate rather freely as a minority population in the economic and political activities of New Mexico as a whole. Their ability to maintain identity is most threatened when families and individuals migrate to urban centers, or leave the general territorial influence of the local pueblo. As economic and other factors sometimes require mobility and participation in the broader 'mainstream', there are an increasing number of persons subjected to cross-cultural stress and many of these are among the 'best customers' of IHS Mental Health Services.



APACHE
and
UTE RESERVATIONS

2. The Non-Pueblo

a. Ute

The Colorado Ute Reservations are the home of remnants of an Aztecan-speaking population, which in its northward migrations before the days of European conquest had mingled with the larger Plains Tribes and developed a culture based partly on the horsemanship and hunting prowess, and partly on the seed-gathering and root-digging economies. One of their famous leaders, Ouray, was born in Taos, New Mexico in 1833, and lived until the 1880's. His generally friendly relationships with the US federal representatives meant a more peaceable settlement for the Mountain and Southern Colorado Ute bands than for most of the Plains Indians. They were granted reservations south of Durango and Trinidad, in the generally thinly populated and unexploited region of southwestern Colorado. Some of their reservation borders on the Navajo, and has been the subject of arbitration and territorial disputes. The recent development of glazed pottery, manufactured for tourist and department store sales, on the Southern Ute Reservation is bringing this group some recognition and attention.

The Utes are among the less well known Indian groups, because of their remote location. Although the southwestern corner of Colorado, and particularly the slopes of the Rocky Mountains included in the Mountain Ute Reservation are orchard and general farming lands, with some irrigation, the general shift of the national economy from farm subsistence to wage-based efforts has seriously dislocated the Ute populations. There seems to be a generalized feeling that these two tribes are suffering from cross-cultural stress and an inability to participate in the majority culture for reasons of isolation

and poverty to a greater degree than most other populations served by the IHS Albuquerque Area.

b. The Jicarilla Apache

The Jicarilla Apache are located in northwestern New Mexico, and are often referred to as the "Quiet Apache" since in modern times they have not been aggressive or belligerent. As do other Apache, they share the Athabascan language family with the Navajos and the Indians of Alaska, and in their religious beliefs and social structure there are many parallels with the Navajo. This particular reservation has gained widespread recognition among outdoorsmen and hunters for its herds of elk, and or large muletail deer. The tribe has developed facilities for hunters, and sells hunting permits for special seasons, deriving considerable revenue. An elk hunting permit for instance costs $500.00, and brings with it a guarantee of one shot at an elk. A limited number of these permits are offered, and are usually all sold six months in advance of the hunting season dates. A new lodge located on a lake, is expected to attract even more recreation-minded outdoorsmen and families.

In addition to this lucrative and developing use of natural resources, the Jicarilla Apache had formerly been engaged in sheep herding, with a migratory pattern among the valleys and mountains that accounts for some of the irregular shape of their reservation. There is still some sheep raising activity, although it is not involving as many of the families as in the past, nor are the migrations as much a way of life. Some cattle, farming, and lumbering are also practiced by tribal members. A few producing oil and natural gas wells are of increasing economic significance.

One interesting use to which some of these revenues have been put has been the underwriting of the production of Hollywood movies. As producers of Western films, the Apache have not tried to progagandise for a better Indian image, feeling that if the profits come to them it is partial compensation for the stereotyping resented in other quarters.

c. Mescalero Apache

The Mescalero Apache are located in the Rocky Mountains that extend into Mexico, within easy driving distance of El Paso, Texas. Their location has been well known since the turn of the century as first an orchard and fruit producing region, but also as a resort and recreational area. Just north are the race tracks and ski slopes of Ruidoso, which are a focal gathering place for all the Southwest. At the present time the Mescalero are developing ski facilities and golf links as well as a lodge, which they hope will enable them to participate in this recreational use of natural resources.

Under the aggressive leadership of Tribal Chairman Wendell Chino, a considerable increase in involvement with the major American mainstream has occurred over the past decade for the Mescalero Apache. They have secured small parts and light plastics assembly contracts, and also have secured housing contracts, hospital services, and a number of other federal benefits often less prominently available for a population of less than 2,000 people.

In none of this modernization does one sense a loss of Apache, and particularly of Mescalero Apache identity. Ponies are numerous in the pastures, even though cars, trucks and airplanes provide other forms of transportation. The Apache language is widely spoken, and customs seem to be observed regarding respect for the elderly and other traditional practices. There is a sense of a proud and capable people turning their

aggressive traits toward commerce and increasing the potential of their resource development.

In the past the reputation for recalcitrance and untreatability of those Mescalero Apache who were identified as patients in distant state hospitals or correctional facilities was probably evidence of the continuity of identity preserved by the relative isolation of the Mescalero from other Indian groups and from massive attempts by federal services to 'civilize' them. However, the reputation of this group seems to be changing as they emerge as a people and enter active participation in the mainstream. Cross-cultural stresses are still a problem for individuals, and the distances involved would make an impenetrable barrier for IHS Mental Health Services if air transport, by private or charter flights, were not a nearly year round possibility.

II. INTRODUCTION OF MENTAL HEALTH SERVICES:

A. William Davis, M.D., 1967

In the middle 1960's the tuberculosis epidemic was still raging in the southwestern Indian population, although some tapering off could be seen. Dr. William Davis, a General Medical Officer attached to the Albuquerque IHS TB Sanitorium describes how when he first arrived there bed rest of long duration, lung deflations, and other methods were still the norm. As chemotherapy was introduced and more modern treatment methods took hold, hospital stays began to shorten, and the physicians could begin to turn their attention to other problems of the population. It appeared to Dr. Davis that the staff paid less attention to the patients as human beings than to their disease entities, and in 1965 he applied

for and was granted opportunity to take a residency in psychiatry at the University of Texas in Dallas.

This training was completed in the summer of 1967, just one year after Mental Health Programs (the three initial Areas of Navajo, Alaska and Pine Ridge) had been established. Upon his return to Albuquerque for active duty, he was designated Chief of the Mental Health Programs for that Area, with status co-equal to other service program chiefs, and set about exploring the Area and planning service delivery.

This appointment was made at least a year before the introduction of any Community Mental Health Centers in the State of New Mexico. Up to this time the only psychiatric resources of the state were inpatient facilities. The State Hospital in Las Vegas, in the eastern portion of the state was remote from any Indian population. However, the Beralillo County Indian Hospital had an inpatient ward (2-West), and the medical school of the University of New Mexico was developing a psychiatry department. Dr. Davis began planning contacts with the university and also with the County Medical Facility on land adjacent to the IHS hospital and not far from the university campus. The County facility became an integral part of the Beralillo Comprehensive Community Mental Health Center when it was formed in 1970. These relationships, initiated by Dr. Davis, remain an important part of the program over the years, and have increased with the development of staff and programs at all three places.

For the first six months Dr. Davis visited the Service Units, communities and supporting facilities in the Albuquerque Area to gain a more detailed overview of the problems and the peoples with whom he would work. Although not a stranger to the region, his former IHS experience had been within the framework of the TB sanitorium, and he foresaw that Mental Health

programs would be field based. Early in 1968 he presented a statement of his views as to the goals and operations of an adequate Mental Health Program or branch for the Albuquerque IHS Area, and began the recruitment of staff. This report is given in full below because it outlines many of the basic premises and trends that were elaborated in the ensuing years.

OUTLINE OF PERSONNEL REQUIREMENTS
AND PROGRAM PLANNING

The Mental Health Branch of the Albuquerque Area Office, Division of Indian Health, is charged with the evaluation of mental health needs and the rendering of direct and consultative services for a group of approximately 30,000 American Indians. This population is scattered among fairly well-defined small reservation communities throughout the State of New Mexico. There are 19 Pueblo, 2 Apache, 3 Navajo, and 2 Ute reservations. These vary in population from 100 or more to approximately 5,000. To varying degrees the communities are considered to be socioeconomically deprived. Although a great deal of effort has been made in improving the general medical situation, sanitation, education, and sociological interchange, there still remains much to be done.

Attention here is directed more specifically toward the emotional difficulties arising from the above-named situations. Also, the efforts on the part of the people themselves toward becoming more effectively related to a different society and culture have not received formal attention until recently. Much of what is outlined in this program cannot be presently substantiated by statistical facts but is indeed a tentative type of proposal, based on the impressions gathered from visiting communities and Public Health Service Units, as well as many schools.

The Mental Health Branch does represent to some degree a pioneer effort and, as a consequence, does lack specificity. As continued contact with the people progresses and a more detailed evaluation of needs is obtained, it is hoped that the program will have sufficient flexibility in direction of interest to deal with new factors and concepts.

The program presented will, of course, have to evolve over a period of time and, in fact, even if all of the proposed personnel were immediately available, it is doubtful that the personnel could be used effectively at this time. Our current lack of exact knowledge of needs would seem to indicate that a gradual and sustained increase in programing will be more effective than any type of "blitz" tactic.

Several years of working with the people will, undoubtedly, result in knowledge which will in one way or another cause modifications in program aims and structure.

From July 1, 1967 to the present time, the Mental Health Branch has consisted of a psychiatrist (the undersigned) and a secretary (stenography). Mrs. Vesta L. Starkey, Chief, Medical Social Service Branch, has been very helpful in the search for medical social worker personnel, and participating in discussions about the overall aims of the Mental Health Branch. It is certainly expected and will be appreciated when new members of the staff will be able to contribute their own thinking about the program. At the time of this writing, one senior social worker will join the staff within a few weeks, and another psychiatrist is expected on July 1, 1968.

The main purpose of the current outline is two-fold in that it will be circulated to interested personnel in the Division of Indian Health, and to those people at the National Institute of Mental Health who have shown a continued interest in our work.

1. Immediate Needs:

   a. Two psychiatrists, Board certified or Board eligible,

   b. Two senior social workers with Master's degree and three years of experience,

   c. A clinical psychologist, Master's degree or Ph.D., and

   d. One registered nurse with three years of field experience, and preferably formal training in mental health.

The anticipated supportive secretarial personnel for this group of professional personnel will be three secretaries (stenography).

2. Needs in the Immediate Future:

   a. Six field medical social workers, Bachelor's degree, and

   b. Six trainees selected from Indian communities.

It is not anticipated that the field social workers would in all cases need the services of individual secretaries, and it might be possible to share this type of employee in cooperation with other needs of the Service Units.

The trainees would have the very difficult job of bridging the communications gap between professional personnel and the Indian people. It would be hoped that the trainees would be able to help the personnel without over-identification with them at the expense of losing meaning-

ful contact with their own people. This poses a difficult but not insurmountable task.

The junior social workers and community trainees would be placed in locations throughout the State, according to indicated needs which have not been fully determined at this time.

3. Future Desirable Personnel:

a. Sociologist, Master's degree or Ph.D., candidate, or

b. Anthropologist at equal level of professional development.

The above organizational pattern does indicate that the senior professional personnel would have priority as to time in being recruited. This is thought necessary in view of the fact that training of the personnel at the field level is a priority item. It is not meant to reflect any intention of minimizing direct services to the people; in fact, it is anticipated that these senior members of the staff be concerned with direct services to beneficiaries and consultations with other disciplines as long as the program continues.

Briefly stated the following activities are anticipated for the senior personnel. The two psychiatrists would have overall responsibility for the program itself and for the continued attitude that the mental health program is indeed a part of the overall program for Indian health. Primarily, their duties would be that of psychiatric evaluation; brief and long-term clinical psychiatric contact with patients and consultation with people at Division of Indian Health Service Units and of other disciplines on Area and local community levels. This would include tribal officials, tribal judges, Bureau of Indian Affairs and public school personnel, State mental health workers at both the State Hospital in Las Vegas and at the Area Mental Health Offices throughout the State. Another area of duty would be the provision of training of and consultation with the personnel at the various Indian Boarding Schools. This would include dormitory attendants, teachers, and guidance counsellors. Their role as substitute parents makes them uniquely useful on both preventive mental health and assistance in the treatment of emotionally disturbed students. Also continued exchange of ideas would be promoted with Division of Indian Health Area personnel and the University of New Mexico Medical School, Department of Psychiatry.

The tentative plan, as far as field work is concerned, would probably be that one of the psychiatrists would have more immediate contact with the northern communities, while the other would have similar responsibilities in the southern and the western portions of the State. However, efforts will be made to avoid distinct geographical divisions of interest.

The two senior social workers would have a similar division of responsibility to that outlined above, with the exception that it may be more practical for one of them to be based at the Santa Fe Service Unit, while one would be at the Albuquerque Area Office. A mental health register would be maintained at the latter location.

The clinical psychologist would have overall responsibility for determining the need for and supplying services in regard to psychological testing. This staff member would probably be working in close cooperation with school personnel, and would also act as the liaison person, dealing with psychologists currently working for other agencies. It would be anticipated that the psychologist have an interest in devising new methods of testing or new interpreting methods of existing tests to render these more applicable to the people, especially children.

The registered nurse would be selected on the basis of primary interest in mental health problems, and would be expected to work with both Service Unit and field nursing personnel, including LPN's and trainees. It is thought that her duties would be based primarily on the concept of consultation, training, and coordination of plans with nurses working with other state, local, and federal agencies.

In is anticipated that the above group as a whole would direct and coordinate the plans for direct services to patients, toward various training programs, and toward interdepartmental cooperation.

The projected need for six or more junior social workers and a like number of trainees is based on the premise that the most effective services must be rendered on a local level; in fact, the most meaningful request for help arises at this level. It is felt by the training of local people that even deeper awareness of local needs may be achieved. To a great degree, all of the above personnel would have the goal of helping these local trainees to do effective mental health work. The selection and ongoing training of these personnel would be of prime importance, as it is thought that through using this system, increased local community action and self-sufficiency can be achieved.

The above brief outline is not intended to ae a substitute for formal job descriptions in all these categories, but is only an effort to delineate a program philosophy.

In January of 1968 the first of the professional staff outlined in Dr. Davis' report was recruited. Mr. Charles Archibald had known Dr. Davis slightly when he was at the TB sanitorium and had deepened

his acquaintance during Dr. Davis' residency. Mr. Archibald was at that time a Social Worker on the staff of the federal hospital for drug addicts at Fort Worth, Texas, one of the facilities with which Dr. Davis secured clinical experience. Mr. Archibald had earlier roots in New Mexico where he moved in 1950 with the U.S. Army Corps of Engineers, later receiving a B.A. in Social Work at the University of New Mexico. He had done follow-up work for the New Mexico State Hospital in Indian communities as part of the establishment of Field Offices in Santa Fe, Albuquerque, and Las Cruces for four years before entering the U.S. Public Health Service. He had completed his graduate work in Psychiatric Social Work at the University of Connecticut, and in Community Mental Health at Florida State University.

Mr. Archibald began his IHS work with a visit to each of the communities being offered services, and to the various installations of IHS, BIA and other facilities with which coordinated effort was to be maintained. His monthly narrative report for February 1968 represents his first full month of service and indicates the scope of this orientation period, as well as how team work began to be initiated along traditional orthopsychiatric lines.

> Upon completion of my first full month, I have made at least two trips to each locale currently being offered direct service by the Mental Health Branch except Mescalero (snowed out).
>
> To familiarize myself with program resources, I have supplemented planning meetings with local health, welfare, and tribal officials by scheduled conferences with:
>
> Dr. James Hancock, Clinical Director, and Mr. Juan Lopez, Chief Social Worker, New Mexico State Hospital (Las Vegas)
> Mr. George Baca, Chief Social Worker, Los Lungas Hospital and Training School
> Miss Judy Hickson, Director, New Mexico State Mental Health
> Dr. Eugene Mariane, Program Director, New Mexico State Department of Health and Welfare
> Mr. George Ludi, Acting Director, New Mexico State Probation and Parole
> Mr. Harry Fahrenbruch, District Supervisor, New Mexico State Vocational Rehabilitation
> Mr. Clarence Acoya, Executive Director, Commission on Indian Affairs

Miss Gertrude Christensen, Coordinator, Albuquerque Child Study Center
Mrs. Ardis Hof, Director, Association for Mental Health
Mr. Donald Ciese, Coordinator, Goodwill Industries Rehabilitation
Mr. Jack Shuster, Director, New Mexico Council on Crime and Delinquency
Mr. Fred Kotzan, Administrative Assistant, New Mexico State Combined Hospital Board

Locally, I have met weekly with the Comprehensive Mental Health Program Planning Staff of the University of New Mexico Medical School, and have attended Psychiatric Grand Rounds to familiarize myself with the professional personalities and treatment philosophies of the Medical School, Veterans Administration Hospital, Bernalillo County-Indian Hospital Psychiatric Unit, and State Hospital Field Staff.

The San Felipe High School Senior Girls Group (10) has been meeting bi-weekly at the Pueblo, with Miss Margaret Wolf, Public Health Nurse, serving as my co-therapist. The confidential contract in an otherwise permissive structure is producing gratifying results in thoughtful opening up of their personal concerns as they consider a life apart from the Pueblo.

In both Laguna and Zuni areas, the schools are acting as the primary source requesting service. Treatment of the children has necessitated the involvement of parents and teachers. The pattern of response has invariably reflected the degree of flexibility of the school's administrator. Group treatment in Laguna, Magdalena (Alamo), and Ramah is new to the schools and they appear somewhat insecure in this introductory phase.

Our Mental Health Register is taking shape, using Form PHS-2731-3, 2-57 (Social Service Worksheet), for each patient treated by us, or identified by the community as "mentally ill". Initially, we are being inclusive of all types referred currently residing in our Area, with culling to take place later as our role may be narrowed.

I accompany Dr. Davis to each setting he serves, but we have begun to multiply our service by dividing the time; i.e., I see mother while Dr. Davis sees child; I talk with teacher while Dr. Davis sees child in school; each one of us sees partner in marital difficulty (then perhaps all together); or I consult on broad community mental health needs with PHN, or CAP personnel, while Dr. Davis sees adult patients.

During the first month, I was not able to expand direct treatment services into new neighborhoods, as I had hoped, in order to catch up on the documentation of the service of the Branch to date. However, regular conferences are held with <u>all</u> the medical and nursing personnel of the DIH serving the entire area, and plan to move into new locales as case-referrals are made.

The subsequent month's report by Mr. Archibald is also revealing for its presentation of the problems of developing mental health programs in cross-cultural settings, and the beginning references to consultation ("treating" the referring source) as a means of keeping from getting silted up with an ever-increasing case load.

> At present the branch has 103 cases in its active treatment file and 42 cases known as having serious emotional problems but have not made themselves available or are yet to be sought out since referral. In addition we have worked with 3 high school senior groups at Laguna High School who could not properly be identified as patients with incapacitating emotional problems, plus 1 group at San Felipe and 1 group at Magdalena High School (Alamo BIA Boarding School 10th, 11th, and 12th grade students). There are from 5 to 10 students in each group.
>
> I spent the morning of March 15th with Warden Baker of the New Mexico State Penitentiary to discuss the treatment of New Mexico Indians serving sentences for state crimes. Since his duties commenced in August of 1967, he has apparently done much to upgrade the Correctional Education and Personal Relations skills of the Correctional Officers he had inherited. Their previous duties had been entirely custodial. This movement has been responded to by staff and inmates alike with hope of a true social rehabilitation program for those who have forfeited the right to remain in open society. He asked that he might call on the Mental Health Branch staff for advice concerning criminally insane Indians, who have been assigned to the prison rather than the minimum security State Hospital, and for informal talks on mental mechanisms to his personnel to assist them in understanding the Indians in general, and in turn offering a more therapeutic service to those whose interpretation of incarceration might otherwise thwart rehabilitation efforts.
>
> My training trip to Chicago March 20 through March 23 to act as Chairman of a Workshop sponsored by the American Orthopsychiatric Association was a stimulating experience, as it enabled me to compare our progress with others offering a Mental Health Program to minority groups. Since the overall theme was THE MENTAL HEALTH FIELD: A CRITICAL APPRAISAL, we were able to divide some popular images from the facts, and break down mass programs to the service level where the effectiveness is usually a reflection of the relationships between staff and recipients of the service. Their experiences often mirrored our own, as attempts to find common factors among patients was illusive, whether they be Negroes, Puerto Ricans, or

Indians. The differentiation between treatment and environmental manipulation was made, but without value judgment as to appropriateness.

Our traveling treatment and consultation service has settled into a routine that can be depended upon by clients and local resource persons. The four outlying corner groups (Magdalena, Mescalero, Taos-Dulce, Zuni-Ramah) are seen once a month for a morning and an afternoon on location, while the four groups within an hour's drive (Laguna, Isleta, Santa Fe, San Felipe) are served every other week. Tuesday afternoon each week is reserved for visits to areas not regularly served, but from whom there have been referrals.

Even with dividing the patients between Dr. Davis and me, either at random or following a conference to identify the apparent needs, the steady increase of referrals while a backlog of sustained treatment cases is maintained predicts a point of maximum saturation very soon. Post evaluation conferences with referring persons and home visits to identify and suggest modifications in approaches not withstanding, there are realistically no local treatment resources in the outlying areas to whom we could pass cases needing long-term outpatient care. Finally, the all inclusive nature of "Mental Health problems" invites referrals of every community problem, and "treating" the referring person for their problem rather than that of the identified patient constitutes a major area of clinical service.

Some of the difficulties in eliciting community enthusiasm for a consultation, education and community-resource oriented mental health program, rather than a program based on providing direct psychiatric services are succinctly described in Mr. Archibald's May report:

> In speaking to the Sandoval County nurses on April 30, I contrasted their experience with hospital treatment of the mentally ill with the community based program we have initiated. Their questions indicated some discomfort with the esoteric nature of our orientation and the often subtle symptoms in social behavior they must look for to catch the mental health cases early enough for a preventive service. Their request for prompt service to the Jemez area will be honored in June.

However, progress toward goals was seen in the school evaluation and group activities that had been developed in 12 schools during the year.

> May is a time for tapering off many school based activities, to be terminated at least until fall, so April is the last regular month of intensive treatment services. The feedback from Service Unit and school personnel of progress reflected in the children in the few short months of regular though infrequent treatment visits is gratifying. We have learned much, particularly in group treatment approaches to a rather different kind of patient than the urban Anglo, and have already begun to experiment with modifications in approach designed to evoke verbal participation. It was felt that we owed it to them to do all we could to prepare them for a verbal world to which they aspire. Otherwise the burden of loneliness may force them back to the security of the familiar, despite their verbalized rejection of its opportunity-less reality.

This last quotation sounds a note that is characteristic of this Service Unit in its sense of responsiblity for preparing Indian youth for participation in mainstream US activities away from their home communities.

By June of 1968 over 200 cases were open and in active treatment, 12 schools had received services on a regular basis, and the two member team was familiar with most of the 26 reservations or communities for whom IHS was mandated to provide services. The Ute reservations had received no services, but individuals from nearly every other community had been seen and leaders of many communities had been given opportunities to learn about the program.

However, by the end of Dr. Davis' first full year (by which time Mr. Archibald had been there 6 months), there was still a sense of mystification in the reports about the needs of the Indian peoples, the prevalence of mental illness among them, and the best methods of treatment and service delivery. This is expressed in an excerpt from the monthly narrative report dated June 4, 1968, reacting to visits from IHS headquarters staff.

> At the end of the month we felt the scrutinizing pressure of the visit of officials from Washington and the request of the Chief of Professional Assignment and Research of DIH for a Comprehensive Report of the Mental Health Characteristics of the Albuquerque Area-DIH. In our present projection of program and staff goals we hope within two to five years to have some reliable data of the type requested, together with supportable impressions of the important why and how to relieve these symptoms of social unrest that warn us of more severe breakdown in the functioning personalities of the Indians. Prior to this time we must admittedly treat that which we do not altogether understand, but we are confident that given time and respect for the need of both sides to understand difference in orientation, the common human needs of those Indian people will be revealed and relieved. Doubling the service to them with the additional Psychiatrist-Psychiatric Social Worker team this summer will do much to earn us a place as a part rather than a visitor of the service units. With additional exposure, requests for service will increase, but only in this way can the word speead that psychiatric treatment services are needed, desirable, and to be sought rather than avoided. Then we will have contact with the shadowy Medicine Men, and our skills in communication to relieve anxiety will be sorely tested.

B. James Andre, M.D., July 1968 —

In the summer of 1968 a second staff member was added, James Andre, M.D., who had just completed psychiatric residency training in Michigan where community mental health organization and administration was emphasized. Dr. Andre's views added a third element to the developing program since he was particularly dedicated to the proposition that only by developing community resources could the Mental Health Program begin to approach adequate levels of service.

With a second psychiatrist it was possible to divide the responsibilities so that Dr. Davis visited the northern half of the Area, while Dr. Andre visited the western and southernmost sections. Mr. Archibald traveled with Dr. Andre, providing Social Services and community liaison, while Dr. Davis utilized the staff of the Social Services Branch, or Department of Public Welfare Social Workers to supplement his clinical activities.

This division of responsibility and attention from the global needs of 26 communities to half for each psychiatrist markedly improved their ability to see each community individually and allowed more time to meet needs on a regular basis. The location of the Mental Health personnel at IHS clinics, health centers or hospitals however, was not the easiest way to develop community programs, since there were too few of these to allow for community representation. A second focus of effort was provided by school consultations, especially Headstart programs, and approximately half the time and energy of each "team" was spent in school-based programs. In preparation for Congressional Budget Hearings in December of 1968 a description of the program was prepared illustrating its time allocations and describing the staff activities. After omitting a brief re-statement of the description of the Area, the report is given in full.

The Mental Health Branch is a service-oriented group primarily as it is thought this is the best way to find what the problems are. Approximately half the time in the field has been directed toward the problems of school age children (this includes Headstart), their families, educators, and related disciplines. Evaluation and consultations are the most often rendered services; a given case usually involves both. Only recently has the Mental Health Branch expanded into the more traditional community-oriented approach of helping people to help one another with emotional problems.

The following is an outline of the schools where services are provided:

NORTHERN SECTION

Name	Number of Visits with Time Spent Each Visit	Type
1. San Felipe Pueblo	Every 2 weeks - 2 hrs	Headstart and Elementary Day School
2. Santo Domingo Pueblo	Every 2 weeks - 2 hrs	Elementary County Day School
3. Cochiti Pueblo	Every 2 weeks - 3 hrs	Headstart
4. Institute of American Indian Arts	Every week - 3 hrs	BIA Boarding High School and Post-graduate
5. San Juan Pueblo	Every 2 weeks - 1 hr	BIA Elementary Day School
6. Jicarilla Apache Reservation	Every 2 weeks - 3 hrs	BIA Combination Day and Boarding School-Elementary through High School
7. Taos Pueblo	Every 2 weeks - 2 hrs	Headstart and BIA Elementary Day School
SOUTHERN SECTION		
8. Jemez Pueblo	Once per month - 3 hrs	Headstart and BIA Elementary School
9. Santa Ana Pueblo	Once per month - 1 1/2 hrs	Headstart

Name	Number of Visits with Time Spent Each Visit	Type
10. Sandia Pueblo	Once per month - 1 hr	Headstart
11. Isleta Pueblo	Twice per month - 3 1/2 hrs	Headstart, BIA Elementary and Special Day School
12. Albuquerque Indian School	Twice per month - 4 hrs	BIA Boarding School, Elementary and High School with part of Students in Public School
13. Magdelena	Twice per month - 4 hrs	BIA Dormitory Staff with Students in Public School
14. Laguna Pueblo	Once per month - 5 hrs	Headstart, BIA Elementary School, and Public High School
15. Paguate Pueblo	Once per month - 1 hr	Headstart
16. Paraje Pueblo	Once per month - 1 hr	Headstart
17. Acomita Pueblo	Once per month - 2 hrs	BIA Elementary School
18. Zuni Pueblo	Twice per month - 3 hrs	Headstart, Public Elementary and High School
19. Ramah Reservation	Twice per month - 1 1/2 hrs	Headstart, BIA Elementary Day and Boarding School
20. Mescalero Apache Reservation	Twice per month - 1 1/2 hrs	Headstart, Public Day School

Total -- Approximately 90 hours per month spent on student problems.

Due to limitations of time and personnel, other small schools are visited on request relying on teachers' meetings, health educators, public health nurses, and PHS service unit directors, etc., for referral

Problems of Indian school children are quite varied. Relative socio-economic deprivation appears to have a profound effect leading to alientation from the mainstream of living. Feelings of insecurity and feelings of inferiority often result from unstable home conditions and contribute to general anxiety and lead to learning difficulties. Rela-

tive deficiency of verbal communication, especially in English, between parents and children leads to difficulties in learning symbols (letters and numerals) and putting them together. It must also be remembered that these children are not deficient in any way, according to the culture and aspirations of most of the parents, when they are young so the parents are diffident about encouraging their children. Many behavioral problems are referred, particularly in the upper elementary grades, and learning problems are referred from the lower grades. Older elementary students do not have their basic learning and become bored and frustrated. There is much truancy and many dropouts. Functional retardation is much more prevalent than true retardation due to birth injuries or congential disease. Overt psychoses in children are seldom seen but neurotic conflicts are very common. Sociopathic and self-destructive behavior is very evident and drinking alcohol is a problem, particularly at high school level.

Boarding school students have the same basic difficulties as day students with the added complication of being required to relate to two sets of "parents" who come from different backgrounds and have different values and goals and different basic languages. Also, boarding school students are often those who were not able to function well in their home communities or those whose parents could not cope with rearing their children. The "generation gap" seems wide among Indian families.

Generally, dormitory attendants have a genuine regard for and interest in their students but most of those consulted say they would welcome more training and more co-workers. We are not able to undertake any formal training programs at this time. Group therapy with students is being tried at the Institute of American Indian Arts and Jicarilla Apache Boarding School.

The Mental Health Branch makes much use of indigenous personnel in the various communities and schools in the followup care of patients who have been evaluated and a treatment program has been outlined for. For example, we work directly with the BIA psychologists and dormitory personnel at the Institute of American Indian Arts and the Albuquerque Indian School; also, with the Ramah, Jicarilla, and Magdalena dormitory personnel. These people and other personnel have been, for the most part, interested and cooperative and we feel as time goes on they will be even more effective as their mental health "expertise" increases. There is a need, however, for more support for these people on a more readily available basis which could be supplied by social workers on a local level. They need not be exclusively engaged in mental health work but would be important foci for the communities on a continuous basis. There are long intervals between visits of the Mental Health Branch consultants as noted in the schedule. There is a feeling of "starting all over again" if the community is visited only every two weeks. They could also help train and supervise Indian people to work as mental health aides.

Aside from the work done at the schools, there are general mental health clinics which are held for evaluation, diagnosis, and treatment. Of course, some student problems are seen in this context, also, as well as family and community problems related to students. Consultations and treatment programs are discussed with professionals and families at these times. This is the area in which social action and other elements of a comprehensive program are promoted and coordination with other agencies is planned and discussed. We feel these clinics held in the same setting, and often at the same time as the general medical clinics operated by IHS help, incorporate mental health services with the overall IHS medical program. The Mescalero Apache tribe has a tribal health council which has been a great help with our efforts in their community.

Following is a list of the regular mental health clinics for adults and children:

Name	Number of Clinics with Approximate Time Spent
Santa Fe Hospital	Once a week - 3 hrs
Jicarilla Health Center	Twice a month - 5 hrs
Taos Health Center	Twice a month - 4 hrs
Jemez Health Station	Once a month - 5 hrs
Isleta Health Station	Twice a month - 2 hrs
Albuquerque Indian Health Center	Twice a month - 2 hrs
Laguna Health Center	Once a month - 3 hrs
Zuni Hospital	Twice a month - 8 hrs
Ramah Health Station	Twice a month - 2 hrs
Mescalero Hospital	Twice a month - 10 hrs
Albuquerque TB Hospital	Once a week - 1 1/2 hrs
San Juan Health Center	Twice a month - 2 hrs.

A mental health register is being compiled in the Mental Health Branch as the work continues.

As can be seen, we have been attempting to gain some broad knowledge of many communities rather than to have the staff concentrate "in depth" on a few areas. We see ourselves as a field operation.

As will be noted from this report the number of places visited has been reduced somewhat. Efforts to reduce the travel for the southern team each month involved investigation of possibilities of utilizing air charter services to at least Mescalero and Zuni Hospitals, a procedure which was later established. Someuse of the travel time could be made where two or more staff members traveled together for case review and program planning.

The description of program objectives, and of priorities and philosophies that were tentatively agreed upon by the three professionals is included in the annual report prepared for the Area Director covering the year July 1968 through June 1969. The first few pages of this report repeat descriptive information that has already been presented here concerning the nature of the Area, but the report is quoted in full beginning with the reflection by the staff upon the uniqueness of the Area and the problems it poses for them.

> Public health services are well accepted throughout the Area, receiving the support of the Indian religious and healing practitioners as well as the civil authorities. Consultation with staffs of the reservation-based schools was a primary focus of our prevention emphasis, plus the off-reservation BIA boarding facilities of the Institute of American Indian Arts, the Albuquerque Indian School, and the Magdalena and Ramah Dormitories. The team utilized individual, family group, heterogeneous group, and staff interactional group methods of investigation of problem areas; supplementing emphasized consultation with formal training programs as we were called upon by health educators, service unit directors, school principals, and others. While aware of the handicap of the lack of reliable baseline data as to the incidence and prevalence of emotional problems on the reservations, we feared that surveys instituted before mental health as part of total health was understood and accepted by the Indian people would be unwise and unproductive. We were careful to avoid the impression of our imposing a program on a community based upon a format found effective in a non-Indian setting. Consequently, during the early stages of our work, programs have evolved in each community with unique characteristics reflective of the personalities and mores involved. It has then been necessary to attempt modification of accepted norms regarding community mental health through various methods of health education. . .
>
> C. Changes in July 1968:
>
> The assignment of Dr. James M. Andre provided an opportunity to divide the clinical staff into two teams, with Dr. Davis serving the northern portion of the area and Dr. Andre and Mr. Archibald serving the area central, west, and south of Albuquerque. Dr. Andre had recently completed his psychiatric residency training in Michigan that emphasized the community mental health approach, which coincided with the readiness of the branch to suggest new approaches to the community leaders for their consideration aimed toward the goal of a Comprehensive Community Mental Health Program.

This provided for twice monthly trips to each of the major committies and our availability to any of the smaller villages having special needs, such as promiscuity, suicide, drinking, or other psychiatric problems. This increased involvement permitted us to take the next step, that of organizing regular planning meetings of representatives of community groups to work together more effectively, based on our observation of gaps in understanding of the human dynamics that may have contributed to problems rather than to solutions.

II. Objectives of the Mental Health Branch:

A. Initial Convictions:

1. Mental health is a part of total health, and as such is the responsibility of all health related personnel.

2. The scope of mental health concerns goes far beyond the treatment of the acutely disturbed individual to include social and other problems of the family and community.

3. Mental Health practitioners should work closely with Indian religious, healing, and tribal officials to both identify causes for emotionally induced problems and seeking methods of relief.

4. Community mental health involves a delivery of comprehensive services to the community; it is not enough to wait for those who need help to come.

5. Community mental health does not limit the interests of therapy artificially to the identified patient. Instead it aims to improve social adaption rather than attempt intrapsychic reorganization, i.e., it seeks change derived from social action rather than from psychological exploration.

6. If a community provides mental health services that will give potentially distressed persons support within that community, it will sharply reduce the need for psychiatric beds in institutions outside the community.

7. If Mental Health Branch clinical personnel are to function in the most effective (preventive) manner, the small number available must be deployed on a priority basis for consultation and education as well as toward direct services.

8. The mental health team can provide diagnostic evaluations on some cases with consultation following and continued therapy with a selected few if it appears the treatment of choice.

B. Objectives for 1968-1969:

1. Begin to identify those characteristics of each Indian community that may affect the mental health of its citizens, being careful to use the local standards for good mental health rather than those characteristic of an urban community.

2. Be wary to distinguish between those characteristics that are uniquely Indian from those found in other poor, rural, or minority groups.

3. Help the PHS staffs to recognize Mental Health Branch personnel as resources to assist them continually in the development of the mental health component of their total health program, rather than identifying them as a periodically available psychiatric treatment team.

4. Act as a catalyst in assisting both PHS staffs and tribal representatives to recognize the necessity and value of joint planning and coordination of a comprehensive health program that will utilize the strengths and resources in each of the interacting systems.

5. Act as a catalyst in helping tribal officials and staff of the University of New Mexico School of Medicine to understand the advantages of working together in the Indian communities in order to mutually appreciate the goals. This is designed to overcome the handicaps of understanding the Indians' point of view when their sole interaction with staff was in the Bernalillo County Medical Center.

6. Offer our assistance to all Bureau of Indian Affairs personnel in the Indian communities in identifying the mental health aspects of their work, and by consulting on proper approaches to achieve their assigned goals. BIA schools and boarding dormitories are prime collaborators in our preventative programs.

7. Working with community representatives of state agencies such as the Vocational Rehabilitation Service and the Commission on Alcoholism to avoid duplication of services.

C. Long Range Objectives:

1. Promotion of field positions in the communities in cooperation with Area Social Service, Health Education Service, and Community Health Representative programs. Incumbents need not be interested in mental health exclusively but could receive in-service training in mental health practicies.

2. Increased emphasis on community involvement in mental health programs. Community Health Representatives can be important contacts in this endeavor.

3. Increased emphasis on inservice training for service unit directors, public health nurses, clinic and hospital nurses, and their aides. Increased short-term hospitalization of emotionally disturbed patients in the Area PHS hospitals could result from this due to the increased awareness.

4. Expansion of activities in the emotional problems of children and families in cooperation with the newly appointed Area Maternal and Child Health consultant.

5. Continued cooperation and consultation with agencies and communities involved in alcoholism programs.

6. Expansion of the already active involvement with BIA, public and parochial school principals, teachers and guidance personnel and dormitory attendants.

III. Nature of Service Provided:

A. Typical Monthly Schedule:

Northern Team (Dr. Davis)

	Monday	Tuesday	Wednesday	Thursday	Friday
1st Wk.	Area Ofc TB San	UNM-Med. Sch. Albq. Fld. Hlt. U.	San Felipe Santa Fe	Dulce	Taos
2nd Wk.	"	"	Santo Domingo Jemez	Santa Fe Hospital	San Juan Santa Clara
3rd Wk.	"	"	San Felipe Santa Fe	Dulce	Taos
4th Wk.	"	"	Santo Domingo Jemez	Santa Fe Hospital	San Juan Santa Clara

Southern Team (Dr. Andre and Mr. Archibald)

	Monday	Tuesday	Wednesday	Thursday	Friday
1st Wk.	Area Ofc Isleta	UNM-Medical School	Magdalena BIA Dorm,	Mescalero	Mescalero
2nd Wk.	Area Ofc Alb. In.Sc	"	Laguna-Acoma	Ramah Zuni	Zuni Ramah
3rd Wk.	Area Ofc Isleta	"	Magdalena BIA Dorm.	Mescalero	Mescalero
4th Wk.	Area Ofc Alb. Ind.Sc	"	Laguna	Ramah Zuni	Zuni Ramah

B. General Activity Report, Mental Health Branch (Six-month period):*

Activity	Number of Hours
Diagnostic Evaluation	118.50
Individual Treatment-Child	40.0
Individual Treatment-Adult	68.50
Group Treatment-Parent/Child	4.50
Group Treatment-Adult Couple	0.75
Group Treatment-Family	6.75
Group Treatment-Unrelated Children	16.75
Group Treatment-Unrelated Adult	19.00
Consultation-Patient Oriented	111.00
Consultation-Consultee Oriented	49.50
Consultation-Program Oriented	69.75
Training-Individual	2.50
Training-Group	42.00
CMH Planning Meeting-IHS	91.00
CMH Planning Meeting-Other	37.75
CMH Planning Meeting-Mixed	30.00
Tribal Meeting-Individual	9.00
Tribal Meeting-Council	1.50
Tribal Meeting-Committee	22.00
Mental Health Talk	18.50
Mental Health Staff Meeting	29.00
Special Problem-Alcohol	5.00
Special Problem-Suicide	4.25

* * *

*This appears to be one staff member's account of how he spends his time, rather than a composite for the staff as a whole. (CLA & MB)

IV. Progress to Albuquerque Area Mental Health Program:

A. Objectives Achieved and Unmet-Reasons for Success or Failing Short:

1. We have begun to identify certain characteristics, both for the general Indian culture and within specific local Indian communities which may relate to the incidence and prevalence of community mental health problems. For example, it is typical of most individual informants to hold persons blameless for most dysocial behavior if associated with drinking, i.e., "He didn't really mean any harm, he was drunk." This is a major consideration that must be met as concerned community representatives attempt to mobilize resources to meet a growing problem.

   It is suggested that drinking extent may be reflective of both a lack of other recreational pursuits and additional frustration with other real and imaginary blocks to a full and productive life, and hence far more prevalent than in Anglo communities of comparable size.

2. As has been noted in other Indian areas, those tribal members who exert power through elective, religious, inherited, or informal status are not often accessible to public health personnel, or if they are they use the device of silence or apparent misunderstanding to void confrontation on points of disagreement. Patience is required in respecting the more leisurely pace for decision making. While support of a program led by "outsiders" may be given in words, it may be much longer before true support is manifested by significant tribal participation. When there is no significant movement in the direction advocated by the outsider, this should alert the potentially helping person to review his goals, methods, and pace for points of difference of vagueness in regard to what the Indians want and why.

3. The acceptance of the mental health component of total health has varied among service units. For the most part this has not been a resistance to the principle itself, but rather to the time and special handling of the psychiatric case. In a not infrequent number of cases the prejudices and emotional health of the provider of service has restricted his comfort when called upon in this role. Consultation and inservice training programs have reduced this resistance, but at times even individual insight directed psychotherapy has not sufficiently reduced the staff members reluctance to serve the emotionally troubled person. Service unit staff members

and tribal policemen are beginning to show greater recognition of what constitutes a mental health problem, see the need for prevention at least as much as rehabilitation services, and for broader use of mental health team than diagnostic and treatment services alone.

There is a natural tendency to see mental health as our Branch's program, rather than uniquely theirs. They are "modest" of their own abilities, wishing to emphasize the expertise of the traveling team. The emphasis on "Community" is foreign to their view of a caseload of the defined ill.

Constant staff changes show that formal and informal mental health education is a continuing process, never completed and constantly adapting to pressing community concerns. We hope that staff members who do continue may take on at least "teaching aide" roles during inservice training under Mental Health Team supervision.

4. By participation as consultants in on-going community health programs we have been able to improve coordination and collaboration among agencies: tribal, PHS, BIA, state, etc. Ideologically people see the need for this working together, but the press of other duties can conflict at times, especially when questions are raised as to the accomplishments of the first or second meeting, when "magical thinking" is frustrated by the lack of quick and simple answers to complex problems.

While the policy of Indian involvement is moving from their being informed of the delivery of services to their actually initiating and modifying them, the primary direction comes first from the Area discipline heads, secondly from the Service Unit Directors, and third in response to unique needs observed in the local communities. In the single instance observed where tribal leadership has the influence to back up demands for local response, the process is completely reversed. A middle ground would be desirable, where service unit personnel may function as an essentially autonomous team, utilizing local Indian Advisory Committees to keep them abreast of the level of rapport with the community and as a channel for two-way communication to avoid the necessity of reacting to crisis alone, with the support of Area consultants to provide the tools necessary to meet locally originated programs.

Encouragement of coordination and collaboration among local resources is of the highest priority of a Community Mental Health Program, but it can only become a reality if there is confidence of support from above. The Mental Health Branch personnel hope to be more available to Area Personnel for consultation and education in order to emphasize the emotional factors that are a vital part of all relationships between the deliverers and recipients of health services.

5. Certain college departments, such as anthropology, sociology, and education, have long been interested in the challenge of a radically different culture adjacent to and partially intermixing with the dominant urban culture. This year the University of New Mexico Department of Psychiatry and School of Nursing made overtures through site visits and one-shot orientation experiences that they would like to establish on-going clinical programs in select Indian communities. There was some surprise when their offer was greeted with hesitency and even some skepticism on the part of tribal leaders. Upon closer inspection, the reasons for this "too often studied" group's resistance were understandable, because they had been questioned, stuck, dug around, and abandoned many times before with little to show for their cooperation.

   Our branch feels that there must be value in training professionals in the field so they will understand the unique characteristics of Indian community life. We will continue to support the establishment of the first satellites in Jemez and Isleta Pueblos.

   While movement of medical school personnel into the Indian communities is pending, the Mental Health Branch staff has offered themselves regularly each Tuesday as part of their duties as clinical associates in the Department of Psychiatry to suggest effective approaches to Indian patients and by offering to arrange for followup services in the Indian's home area. In this way the personnel of the Comprehensive Mental Health-Mental Retardation Center can depend on specialized care for this "different" patient group, and the Indian communities sense a continuity of mental health services. In addition, didactic teaching of psychiatric principles for medical students, interns, and psychiatric residents has been supplemented by field experience with the mental health team when special interest in Indians is indicated.

6. The Mental Health Branch has continued to recognize the value for consultation and coordination with BIA staff, particularly in the branches of Social Services, Education, and Law and Order. We have established an effective and mutually profitable relationship, which will continue.

In the coming year we are narrowing our focus, such as from three BIA dormitories to one, for greater visibility and accessibility for day to day concerns. The focus will be on the person in most direct contact with each student in the potentially parenting role -- the Instructional Aide.

7. Consultation and liaison services with various state agencies and their local representatives are a growing and vital part of our efforts. They have been quite receptive to our help. We are currently involved in Community Alcoholism programs in two large reservations and have been successful in catalyzing a comprehensive approach and a spirit of cooperation and collaboration among many agencies.

C. Planned Program Revisions:

1. Our Mental Health Program in the Albuquerque Area is two years old. During the first year we visited all of the twenty-six communities and responded to requests for service; most direct diagnosis and treatment. During the second year bi-weekly visits to the seven major centers of population were established, with once monthly visits to smaller communities. The infrequency of our visits has supported our contention that it is the Service Unit's mental health program rather than ours. The IHS personnel have begun to expand their area of concern beyond the hospital or clinic walls to the community, particularly in programs of preventive mental health, and the Mental Health Branch has supported and encouraged this trend.

2. Inservice training programs will be modified toward a greater percentage of time for feedback application following some stimulating comments on the theme for each session. In this way we will have a better idea whether the didactic material is being utilized and whether our topics are in keeping with community needs. As added opportunity for professional growth, a broad community representation will be encouraged at the case conferences for multiproblem families. We are most aware of the potential conflict between confidentiality and the desire for the people to unite their services for maximum effectiveness. We are in hopes that the value of a coordinated effort can be demonstrated and hence supported by community leaders.

3. Based on the experiences in three BIA boarding dormitories in Magdalena (100% Navajo), Ramah (100% Navajo), and Albuquerque (90% Navajo), we are concentrating our services to the Albuquerque Indian School. This will include a continuation of limited diagnostic and treatment services in the PHS clinic on the school grounds two afternoons each month, program plan-

ning conferences and inservice training with guidance and psychology department staffs two mornings a month, and flexible time for movement into the dormitories for demonstration projects utilizing group dynamics if this is seen as helpful.

4. A year of focusing entirely on the field personnel for understanding and acceptance of the mental health component of total health has shown the need for time being made available for a consultation service to Area heads of departments to reinforce the efforts of field people to codify their approaches. Our half day each week in the Mental Health office has been absorbed by planning activities of our staff of seven, and an additional half day has been set aside by the deputy chief psychiatrist for Area office consultation.

5. The commonality of problems in the various Indian communities has pointed the way to Mental Health Branch sponsored workshops at least Area-wide. The training would emphasize the contribution of each of the community health team members and the necessity of understanding each member's feelings regardin his or her role on the team, as well as feelings regarding the Indian client group served. They would then be able to evaluate the effectiveness of their program and the reasons for it. We must emphasize that this need extends equally to the staff member who has just come from a geographical and social background devoid of Indians and for an Indian staff member born and brought up in the community where he is serving as an employee of the federal government. Such workshops would not be focused on the more acute psychiatric illnesses such as, functional psychosis or organic brain pathology, but rather the social ills such as, alcoholism, suicide, drug addiction, school adjustment, or marital discord. The delivery of services for the emotional components of physical illnesses such as, TB, VD, and rheumatic heart disease would not be neglected nor would the emotional/cultural components of projects such as family planning and sanitation seem out of the realm of concern of a program with a community mental health focus.

We have emphasized throughout this report the hope that the mental health program be the result of cooperative efforts between the Indian people, the various federal, state and local agencies and the Mental Health Branch. We do not regard the opinions set forth as definitive and inflexible and would like to hear from those with whom we work. Your conclusions would be appreciated.

However the results of the previous plans of operation still left all the staff feeling that they were spread much too thin. Dr. Andre's report of September 2, 1969 reflects this problem, and shows some of the moves to reduce travel time and focus staff energies.

> In addition to the provision of regular diagnostic treatment and consultation services, the southern team has finalized plans for the provision of services for the year 1969-70. As a result of extensive re-evaluation of the past year's activities we have come to a number of conclusions that will result in certain changes for the coming year.
>
> In evaluating methods of delivery of comprehensive community mental health services to Indian communities we have found it unwise to attempt "coverage" of all communities in our area. In the past this has resulted in infrequent, i.e., once/twice monthly, visits to all communities served. Further, within each community served we have attempted to provide services to all relevant agencies. For example, in some communities having as many as five schools we have tried providing consultation services to each in addition to PHS, BIA, OEO and tribal agencies. Also, during the past year we have, by serving every community, been driving more than 2500 miles per month. This has made it virtually inpossible to become very familiar with any particular tribe.
>
> Recognizing that the prime mission of any mental health branch in the Indian Health Service is to study the most effective means of delivery of comprehensive community mental health services, we strongly feel the need to consolidate and focus our efforts. Accordingly we have made the following changes:
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> > Services to Mescalero, an Apache community of 1800 tribal members, 210 miles south of Albuquerque, have been discontiuued. Also, services to the Magdalena boarding dormitory, a Navajo community 100 miles southwest of Albuquerque, have been discontinued.
>
> These changes will allow a savings of over 1000 miles per month in driving and five full days of service time. It will also allow an increase of service of 50-100 percent in some areas previously served, e.g., Zuni Pueblo, Albuquerque Indian School, and the Indian School of Practical Nursing. Liaison services with local and state agencies and with other branches within the area can how be provided whereas previously no time was available.
>
> While we regret having to discontinue services to some areas we are confident that we will be able to provide more effective services to the remaining communities.

As part of our liaison relationship with the UNM Medical School we are providing supervised training experience in Indian health for selected students, interns and residents. During the months of September and October a medical intern, Dr. Martin Kantrowitz, will be traveling with the team to the Ramah Navajo community and to Zuni Pueblo. These training trips will occur on the first three Thursdays and Fridays of each month. While Dr. Kantrowitz will be traveling with the mental health team in government conveyence he is to bear his own expenses for food and lodging. The Service Unit Director, Zuni Indian Hospital, has agreed to participate in training opportunities for Dr. Kantrowitz.

The undersigned has agreed to participate in a series of four workshops to be held at the Zuni High School during the months of September and October. Topics to be presented will include "Suicide Recognition," "Alcohol and Alcoholism Among Teenagers," "Normal Adolescence," and "Drug Abuse."

The same problems were also attacked by attempting to develop local resource persons who could begin to assume some of the activities that might be expected of a mental health staff as part of their regular duties. The avenue selected was inservice training programs offered first for IHS staff, and secondly, due to increasing interest and because of their strategic community influence, for the tribal police.

During this month regular diagnostic and treatment clinics were held in all service units within the southern and western areas. While the team's base continues to be the service unit clinic, we are beginning to move toward total community service with various components of a comprehensive community mental health approach. These components comprise the team's emphasis and include diagnostic services, early case identification and treatment, rehabilitative services, consultation and education, and research and evaluation. These components are being developed in an integrated fashion for each community. For example, we are working toward improving case finding, proper referral, diagnostic evaluation, and where possible, treatment and rehabilitation by community resources. Consultation and education play a significant role in accomplishing these aims. For example, in the Laguna and Zuni Service Units, we are providing in-service training to field PHS medical staff. Presently this includes twice-monthly discussions of psychological principles, psychiatric syndromes and the proper use of psychoactive drugs. It is expected that this service will extend to other areas and to other disciplines, e.g., the paramedical staff. The team is prepared to participate in in-service training programs for field personnel including, e.g., physicians, nurses, health educators, etc. The Mental Health Branch has arranged to meet with representatives of the National Center for Epidemiologic Studies in order to plan for meaningful studies relative to the incidence and prevalance of mental illness in the communities served.

In the Magdalena Dormitory the team has undertaken to provide consultation/ education services to administrative, counseling, and attendant personnel in addition to diagnostic evaluation of selected referrals. It is expected that this service area will demonstrate the efficacy of indirect service to many via consultation and education with a small number of key personnel. This is a vlid and essential approach where time and resources are limited.

The team is optimistic about the potential for development of a comprehensive mental health program in the Mescalero Apache community.* We have been impressed with the willingness of the tribal and agency representatives to work with us in evolving a responsive and meaningful program. We have endeavored to present our team as a resource to the community rather than a bearer of a prepackaged program. We are encouraged by the strengths and capabilities of the Mescalero people and by their willingness to work toward improving their community. The Mescalero Agency has an ongoing, unique community meeting designed to focus all available resources on community problems to bring about effective solutions. This meeting may well stand as an example to other communities, both Indian and non-Indian, and the mental health team is happy to be a regular participant.

In the Mescalero community, Mr. Richard Hendrickson, social worker, has been very instrumental in coordinating our services. A large measure of credit is due Mr. Hendrickson for the fact that we have been able to offer varied services to community agencies including head start, schools, special education, youth program, medical and paramedical personnel, and social and welfare services. In no other community served have we been able to base our team in the clinic, yet move toward comprehensive community service to the degree we have in Mescalero. We feel that Mescalero has the potential to demonstrate the comprehensive and effective use of mental health resources.

In none of the areas served has the mental health team presented programs for alcoholism, accidents, suicides, etc. This is based on the realisation that such programs must evolve from within the community rather than be imposed from without. Since these are problems requiring many coordinated services, they are not exclusively mental health problems. If there are to be successful programs addressed to these problems, they must be initiated by the people who in turn must have the responsibility for and control over determining the services (what, how, when, and where). The mental health team is prepared to function as a resource to any community wishing to initiate such programs.

The result of this move was to allow focus of attention on particular communities. For the first time in December 1969 some type of summary of local resources, priority setting, and differentiation by community is reflected in the monthly report of Dr. Andre.

*Note: in an earlier report Dr. Andre had recommended dropping services to the Mescalero. Apparently this recommendation was not acted upon.

In addition to the regular diagnostic and treatment clinics, consultation, and educational activities, we should like to include a few specific comments on activities in certain pueblos.

Isleta -- The focus of Mental Health Consultant's services has moved from the PHS clinic to the larger community, hoping to demonstrate the broader community approach for other service unit personnel. (1) Since difficulty has been encountered in meeting with the tribal council directly, Mr. Archibald has met regularly with a person who attends the council meetings and expresses a socially alert perspective. (2) Consultation to the Community Action Program staff regarding individual problem cases and program approaches. (3) Meeting weekly with the sixteen Neighborhood Youth Corps high school students to assist them in their search for meaningful directions for their lives. (4) Working more closely with the Public Health Field Nurse regarding constructive mental health approaches to persons in their homes; through joint field visits. (5) Continued availability for diagnostic and treatment services in twice monthly mental health clinics.

Jemez -- The largest pueblo of the Sandoval County six is receiving the largest amount of time (two full days a month plus), but is being approached (1) through the structure of the Sandoval County Pueblo Community Action Program, (2) through the PHS Medical Officer and PHN, (3) through the BIA and parochial school catchment, (4) through a village member employed in the BIA Community Development section, (5) through direct contact with village officials at the village chapter house * and the new community center. With each the "integrated, comprehensive, community (members involved)" approach is being emphasized. The ground work is being laid preparatory to a change of village officers.

Zuni -- The service to the schools has now broadened from the initial diagnostic and treatment phase of two months ago, coupled with formal didactic inservice training, to consultation to teachers regarding specific students they had referred, to program consultation (especially regarding the Remedial Reading and yet to emerge Special Education classes). The staffs of the Zuni High School, Towa Yallene Elementary, and St. Anthony's are each requesting additional time; at a time when the appointment of a new Headstart Director has been accompanied by a projected plan of increased involvement with this vital group.

Group therapy has been instituted at Towa Yallene for eight children with problems, meeting for one hour sessions first, second and third weeks.

We have started once monthly visits to the Gallup Indian Hospital for the purpose of establishing liaison with the mental health services of that facility. It is hoped that such liaisons will help us provide an additional mental health resource to the Ramah and Zuni communities.

* Editorial comment: chapter house is a Navajo term and its use here is misleading to those familiar with Jemez. Such transpositions from one cultural context to another are not uncommon within IHS, particularly at the administrative level.

This same interest in and ability to develop training programs was recognized by the Desert Willow Training Center in Tucson, which provided basic instruction for IHS to the Community Health Representatives selected and hired by the tribes. Desert Willow Training Center was also beginning to become interested in the training of Mental Health Workers, especially for the Phoenix Area, and since Albuquerque had long had as a goal the development of such a cadre it seemed appropriate to participate in this training effort. Dr. Andre, and later Mr. Archibald engaged in periodic visits to Tucson, where sections of the core curriculum pertinent to community mental health activities were taught. They continue serving as instructors and consultants to this program.

The National Indian Police Academy at Roswell, New Mexico also engaged the services of Dr. Andre for what became a twelve-hour unit in the curriculum of the police academy. Dr. Andre has continued this activity down to the present time, even though his role vis a vis the Mental Health Program changed markedly over the years.

C. Irene Zyniewicz, R.N., Summer of 1969-

With the new fiscal year another staff member was added, Irene Zyniewicz, R.N., whose experience and training had been in psychiatric nursing and who also had interests in Public Health. Miss Zinceweicz represented a staff member long desired by Dr. Davis as an ally in reaching nursing staffs at the Albuquerque and Santa Fe hospitals, and in introducing an element of mental health considerations to the IHS training school for Licensed Practical Nurses in Albuquerque. Her background of training and residence in Michigan also fitted her to work with Dr. Andre's theoretical orientation and concepts.

It is probably typical of the still unfocused nature of the staff's thinking and efforts that her orientation was to the Area as a whole rather than to particular roles and specific communities. The report of her first month's orientation schedule included two weeks in the northern section, including activities around Albuquerque, and two weeks with the southern team. The listing of activities and personalities to which she was exposed in this brief period is somewhat overwhelming as shown in this report:

> As part of her orientation to the branch, Miss Irene Zyniewicz, Community Mental Health Nurse, spent two weeks with the southern team participating in the following schedule:
>
> 14 Indian communities visited to observe mental health characteristics.
>
> 10 Indian tribal leaders conferred with regarding mental health program plans.
>
> 6 Mental health planning conferences with representatives of community agencies.
>
> 5 Patients seen as demonstration of diagnoses and consultation procedures.
>
> 6 Public schools visited in preparation for coming school year relationship.
>
> 2 Group therapy sessions as participant observer.
>
> 2 Group consultation experiences (case conferences).
>
> 2 Service Unit staff in-service training programs.
>
> 2 Neighborhood Youth Corps program consultations.
>
> 2 Head Start school consultation visits.
>
> 2 VISTA program consultation and in-service training sessions.
>
> 1 In-service training program for police (now monthly in 3 communities).
>
> 1 In-service training for indigenous helping persons.

Apparently Miss Zyniewicz's initial assignment included the LPN school, and the two hospital nursing departments, as well as consultation to field units and communities within a close driving range of Albuquerque. Her

report for October 1969 shows her working alone, or with one or more members of the southern team.

Consultation contracts now have been firmly established with the following programs:

Canoncito School - Once a week;
Laguna Headstart (includes programs located in Laguna, Paraje, and Paguate) - Two times a week;
Laguna Field Health - Two times a month;
Indian School of Practical Nursing (jointly with Dr. Andre) - Two times a month;
Santa Fe Hospital, Nursing Department - Once a month;
Chief, Nursing Services Branch - Once a month.

In view of the cooperation and interest expressed by the personnel of these programs during our negotiations, I expect my consultation relationships with them to remain viable.

I am meeting at irregular intervals with the public health nurses from the Albuquerque Field Health Unit, and I anticipate this arrangement to continue as it is for the time being. One of these public health nurses thinks that a women's discussion group about family relationships and problems could be developed at Isleta, and I have agreed to collaborate with her in exploring the possibilities.

The nursing staff at the Albuquerque Indian Hospital has been cited by several sources as a group who could benefit from mental health consultation; however, as you know, so far the overtures of the Mental Health Branch to this group have met rebuff. Perhaps entree to the nurses will evolve indirectly, after the Mental Health Branch responds to the request by the Service Unit administration for inservice training for the physicians.

Mr. Archibald and I have been unable to develop a counseling group with the members of the Isleta NYC program, as we had hoped. It is disappointing to fail, but after assessing the situation, we concluded that our only option was to terminate the project.

Dr. Andre, Mr. Archibald, and I have been meeting with the personnel of the Albuquerque Indian School; Mr. Joe Blanchard, the psychologist, is our primary contact there. I am feeling increasing doubt about my continued participation at AIS, since I question whether the presence of three mental consultants has not caused confusion, as well as contributed to an "overkill" effect.

III. EXPANSION AND DEVELOPMENT OF MENTAL HEALTH PROGRAMS

A. Dr. Davis Continues the Northern Section

During this period more reports are available reflecting the activities of the southern team, and also the work of Miss Zyniewicz. However, Dr. Davis continued his work in the northern tier of communities, focusing primarily on offering treatment and diagnostic studies of individual patients. He was not, however, indifferent to or leaving unattended some of the community development activities that characterize the bulk of the southern team's efforts.

Noteworthy particularly is the development of interest in mental health services in the two furthest groups under the northern team. His report covering work for the month of November 1969 illustrates developments with the Colorado Ute tribes and the Jicarilla Apache at Dulce.

> On December 12, met with the Southern Ute Tribal Council at Ignacio. The council members talked of their concern about delinquency, misuse of drugs and alcohol as being among the biggest problems. They also expressed a need for a mental health clinic.
>
> On December 13, met with Mr. Robert Boe, of the Southwest Colorado Mental Health Center, in Durango, and it is felt that this group can supply the clinical support to the community. During the past year, twelve people from Mountain and Southern Ute were seen at the clinic. We talked about the method of payment to the clinic for services rendered. It was decided that the community efforts in mental health could be worked with by the Albuquerque Area staff with the help of Health Educator and Medical Social Worker from the Santa Fe Service Unit (Chief of the Mental Health Branch is scheduled to give a talk on drug addiction the evening of December 12). A full report of this trip has been submitted separately.
>
> On December 13, participated in a community meeting at Dulce. A panel of high school students talked about their community concerns. This meeting was set up by Mr. Alfonso Medina, Guidance Counselor at the Dulce School, and Mr. Victor Werner, Director of the Program on Alcoholism. A similar meeting with more participation with parents has tentatively been set up for December. Personnel at the Dulce Indian Health Center have a definite interest in the community and participated quite effectively.
>
> Weekly meetings in recent months with Mr. Robert Plunkett, Chief of Guidance Service at the Institute of American Indian Arts, has greatly facilitated Mental Health Branch's involvement with the students, faculty, and guidance personnel.

Other reports during this fiscal year detail meetings with tribal chairmen or governors of various pueblos and talks at public meetings to foster broader understanding of IHS Mental Health Services. Some of Dr. Davis' discomfort with consultation and education processes is reflected in the comments in this report.

> On December 18, a Mental Health Conference was held at Santo Domingo with participation by PHS clinic personnel, Bureau of Indian Affairs, state social workers, school nurse, and assistant school principal from Santo Domingo. Discussion centered around problems of handicapped children in the public school.
>
> Also talked about inquiries by Santo Domingo CAP Director and other interested citizens who wish to attend case conferences. It was decided that we would be happy to have these people to attend, but that it would necessitate a change in the format from the strictly clinical conferences, which have been held in the past, to a more community oriented approach. We feel that both clinical case conferences and community type meetings can be held in Santo Domingo.

B. Tensions Between the Two Psychiatrists

From the beginning the two psychiatrists represented different schools of thought, background and training. Although there were efforts on the part of IHS Headquarters to help the two see themselves as complementary aspects of a complete mental health program, resolution of these tensions was difficult. One had the feeling that Dr. Davis felt strongly that direct services were of primary importance, and that the development of community resources came second in priority.

Dr. Andre, on the other hand, represented the polar opinion that staff could not afford to become silted up with the provision of services, since the demand would be insatiable once they were made available. He preferred to mobilize and train a variety of community persons, and as can be seen, once his travel schedule was reduced he began to do this quite effectively. Mr. Archibald, with a social worker's orientation to the community, was inclined toward trying to involve community persons, but often expressed impatience with their resistance to ideas and programs he and other staff members proffered. He continued to feel mystified about the real needs of the communities and must at times have had a confusing task trying to act as a PR representative to two quite different approaches to mental health needs. Miss Zyniewicz's role in this polarity is not at all clear from her reports, although she obviously worked with all three men at times.

These tensions were finally resolved, not so much by an ability for consolidating the skills and expertise represented, as by administrative decisions outside the complete control of the Mental Health Programs Branch. Dr. Andre's salary initially came from his Mental Health Career Development grant, as did Dr. Davis' salary during his first two years. The budget for Mental Health Programs did not increase sufficiently to begin paying Dr. Andre at the end of fiscal 1969-70, when his grant expired. However, his general interest in program development had been recognized by the Area Office, and he was transferred from the Mental Health Program to the Area Program Development Branch, an office to which Mental Health, Social Services, Health Educators, and other special programs reported for consultation, administrative assistance, and planning.

In his new capacity Dr. Andre continued his work at Zuni-Ramah as Mental Health Consultant, and also continued his teaching at the Tribal Police Academy. He was occasionally available for other inservice training or public speaking engagements, but did not continue as a regular member of the Mental Health team.

C. William Douglas, Ph.D., 1970-

During this period two additions were made to the staff and a number of shifts occurred in "team assignments". William Douglas, Ph.D., joined the staff in the summer of 1970. A native son of New Mexico, Dr. Douglas has experienced the Area and its cultures in a variety of roles ranging from that of policeman to field anthropologist. He is a pilot of small aircraft and also an active balloonist. After academic work in anthropology at Stanford and the University of New Mexico, Dr. Douglas had joined the staff of the Department of Psychiatry of the University of New Mexico Medical School.

There he had developed clinical expertise in both inpatient and outpatient settings as well as applying his skills to analysis of mental health programs.

The move of Dr. Andre away from full-time to part-time specific involvement with the Mental Health Program, and the planned arrival of Dr. Douglas, meant a shifting of personnel in several ways throughout the Area. Dr. Davis refocused his travel to limit northward consultations to Santa Fe IHS Hospital and Service Unit, and became available for some work in the southern district. Mr. Archibald moved to Taos and chiefly became consultant to the outlying Northern Apache and Ute tribes, and to the pueblos close to Taos. Miss Zynciewicz focused her energies as before in the Albuquerque and central to westward pueblos with some nursing consultations in Santa Fe. Dr. Douglas, who had a small plane pilot's license, began to serve the Mescalero. Because of his involvement with the planning at the University of New Mexico Medical School, he also became consultant to Jemez Pueblo and extended his responsibilities to include San Felipe and Santo Domingo, with monthly visits to Zia, Sandia and Santa Ana.

These changes were not without their repercussions. Mr. Archibald reports that the northern communities expressed shock when he explained his role as that of consultant and community organizer or facilitator, rather than continuing to provide direct clinical services in the model established by Dr. Davis. Dr. Douglas' inclination toward clinical services was probably more easily accepted, partly because services to the Mescalero had been suspended for about a year, and partly because it is easier to provide a concrete service than to offer consultation. This was also probably true of Dr. Davis' work as he shifted into communities formerly served by Dr. Andre, which enabled him to spend more of his time in the hospitals and clinic-based IHS offices, seeing referrals or self-initiated patients.

D. Hiring of Mental Health Coordinators: 1970-

In the fall of 1970, along with the other staffing changes, a major development was the recruiting, training and hiring of a number of Mental Health Coordinators. These were local Indian persons, whose previous background gave them a leadership role in their communities, and who had at least an initial interest in mental health problems and their solution. There was initially considerable confusion about the number of positions allowed in the budget, and for several months the numbers ranged from 10 to 4 to 7, and at one point a request for 25 was even entertained. By November the first selections had been made and the 6 persons hired spent the month at the Desert Willow Training Center. By December they were installed back in their communities as follows: Jicarilla Apache, Canoncito Navajo, Taos, Zuni, San Felipe and Isleta Pueblos. In mid-1972, Mental Health Coordinators were recruited and trained at Jemez, Acoma, Santa Clara and San Juan Pueblos and at Mescalero Apache.

These Mental Health Coordinators were given this title by the Albuquerque Area to emphasize the fact that in their paraprofessional capacity they were not expected to be offering professional services to individuals so much as to coordinate efforts at the local level to develop and operate programs of a preventive or remedial nature, and to be the linking resource between IHS Mental Health professionals and the community.

The Mental Health Coordinators came from a variety of experiential backgrounds in community action, National Youth Corps, tribal enterprises, and alcoholism programs. Following their month's initial training at the Desert Willow Training Center, they hold group meetings following the regular weekly staff meetings of the Area professional staff.

Mr. Charles Archibald was given the responsibility for coordinating the training and development of this cadre of personnel, and arranged for them to participate individually in the Social Work Assistant's training program or other courses relevant to their personal interests and available through local educational institutions. Administrative supervision of the Mental Health Coordinators seemed to be a matter for the local Service Unit Directors, with assistance from the Mental Health professional with whom they linked into the IHS system. Since the arrangement in Albuquerque formally placed the four Service Units at Albuquerque, Santa Fe, Zuni Hospital and Mescalero Hospital, most of the Mental Health Coordinators had little difficulty with a program of being available at irregular hours, such as for evening programs and late conferences with persons in crisis. They were very much on their own, to establish their activities and schedules as seemed best to them in light of local needs.

Widely divergent emphases and programs have developed, including a number of sports programs and recreation developments for teenage and young adult groups, alcoholism program supplementation, and work with families and individuals around problems of youth caught in conflict with the law and social codes. The two paraprofessionals at Zuni and Mescalero appear to most closely integrate the roles of interpreter and therapist evolved for the Navajo and Pine Ridge Mental Health Workers, while the community organizing and program commitments of others resemble patterns found in the Billings Area. The interests and skills of the contact professional, as well as the latent talents of the paraprofessional, seem to determine the direction of the program as much as the characteristics and demands of the community.

With the exception of the position at Isleta, which has been filled twice, all the original Mental Health Coordinators have remained on the job since being recruited. Several have developed considerable proficiency at their specialties, and at least two have obtained Associate of Arts degrees as a result of their training and opportunities to study at colleges which supported their involvement in the IHS Mental Health Programs. The involvement of this cadre of paraprofessionals marks a real turning point in the growth and direction of efforts of the Albuquerque Area Mental Health program. Unfortunately, detailed documentation of their diverse activities has not been provided, and their influence can only be inferred from the reports of the professional staff.

E. 1971: Albert Hiatt, Clinical Psychologist

In 1971, Mr. Albert Hiatt, a clinical psychologist working on his dissertation joined the IHS Mental Health programs staff. Miss Zynciewicz and Mr. Hiatt made regular trips to the central communities of Laguna, Acoma, and Zuni, working as a team in stimulating over-all Mental Health Program development, as well as utilizing their particular areas of expertise. They began seeing at least a few individuals and couples in conjoint therapy or counseling, as well as developing groups and other modalities of intervention from time to time.

The concentration of this team on a few large communities enabled them to get to know them well, and to see both present and potential growth as a result of their endeavors.

The programs at Laguna are perhaps typical of the lack of positive reinforcement that various persons developing a community approach may recieve. From independent sources it has been learned that the Laguna Pueblo is able through its tribal leaders and community agencies to verbalize quite distinctly the inter-agency coordination and community involvement needed to actively pursue the goals long espoused by various IHS staff. Yet

neither the community in its proposals, nor the IHS staff in its discussions acknowledge one another as an active catalyst. This is perhaps the most appropriate result of seven years of input into community organization and education, but it takes a very strong and self-motivated staff to accept such an outcome and not be wistful for some acknowledgement of their efforts and endeavors.

The IHS team of Zynciewicz and Hiatt continue to be involved at many levels at both Acoma and Laguna, from the problems of individuals in crisis to the consultation with tribal and other officials on personnel selection and program development. They provide support and supervision for the two Mental Health Coordinators, specific services as needed and requested, and considerable support to the community as a whole. They are seen as a valuable resource, and as trusted outsiders who can make a contribution without taking over locally initiated programs.

At the Zuni-Ramah Service Unit an outstanding Headstart program has been developed. The Community Health Representatives were trained in the administration of the Denver Developmental and Vineland Social Maturity Tests, and interviewed approximately 100 families of Headstart children. referred by various agencies. From this initial screening 52 children received individual psychological evaluations, and the local school was able to add one special education class in 1972 and another in 1973. The local parochial school also provides a special education class. This program was undoubtedly built upon the foundations laid by Dr. Andre, but could not have been carried to completion without the special skills and contributions of the psychologist and R.N. to guide and supplement the community effort. Mr. Marc Rose, Social Worker from the IHS Gallup Ward

and Hospital also consults to the Zuni Reservation. With the return of Dr. Andre, a full team and fairly comprehensive range of services are now available to this Service Unit.

1. 1972 and the St. Catherine's School Project

Another project of Mr. Hiatt has been the development of consultation and group therapy activities at St. Catherine's School in Santa Fe. This Roman Catholic school is a boarding high school whose enrollment is approximately 80% Indian. There are a number of reasons for this school being a more agreeable climate in which to work, and for the students to achieve more nearly normal or outstanding academic records. One important element is the family tradition associated with the school. Parents and even grandparents of present students attended St. Catherine's from a number of the pueblos and reservations in the Area. Therefore, the expectations of attending this rather than a BIA school have much support within the family. The school charges a modest tuition, although some scholarships are available, so that tangible evidence of desire to send their children is coupled with expectation of receiving a good education for the investment. There is a selective admission policy, which while not setting high hurdles in anyone's path, does tend to eliminate the disturbed, disturbing, and academically under-achieving student that typically is found in the BIA schools where attendance is seen as a right not a privilege.

The organization of the peer counseling and group therapy activities at St. Catherine's School was developed by Mr. Hiatt through a series of contracts with the College of Santa Fe, Department of Social Welfare, which

provided up to four graduate students spending each a half day a week at St. Catherine's School as resource persons. These students in social work were engaged in field practice associated with their regular course of study, and assumed leadership in becoming known to and involved with the St. Catherine's student body sufficiently well to recruit and organize student body leaders, both boys and girls, in a training program of peer counseling, which was implemented by St. Catherine's School. The IHS Mental Health Consultant, in this case Mr. Hiatt, performed services as a back-up person for the two sets of counselors, and also acted as a referral resource for problems beyond their respective capacities and competence.

This program, now in its third year, has provided mechanisms for consultation and case identification for IHS Mental Health programs, and for integral involvement of the total school -- faculty, administrators and students -- in an ongoing, positively structured mental health program. Mr. Hiatt's role as catalyst, resource, and coordinator has enabled him to multiply his effectiveness and to focus his particular professional skills appropriately. It is understood that an analysis of this program is the substance of his doctoral dissertation, and in this form its publication may also be available as a model for IHS in other settings.

2. Other activities: Laguna and Acoma

Mr. Hiatt and Miss Zynciewicz function together as a team visiting the Laguna and Acoma Pueblos, and find that this extends the services of each and makes more effective use of their limited time in each community. Acting as co-therapists they see families referred by the Mental Health Coordinator at Acoma and the CHR's and other appropriate staff at Laguna. Separately they provide consultation to a variety of agencies, and are able to establish inter-agency conferences quite efficiently. Their support of key

persons and gradual accumulation of knowledge of the social structures in these complex communities seem to be paving the way for a better integration of IHS acitvities in the total range of services provided by many agencies to these two Pueblo groups.

However, the task is not always easy, since Acoma and Laguna are frequently seen as feuding communities -- on many levels. The youth of both Pueblos share a common high school, and rivalry often reaches a pitch resembling gang warfare in urban settings. The courts are accused of partisanship, each Pueblo tending to see the juvenile and adult courts of the other as more lenient to its own population and harsher to the outsider who might travel the roads or utilise the same social facilities.

This suspicion and distrust may have very old roots. In contemporary times one notes that Acoma still maintains its traditional religio-political structure, while Laguna has opted for the constitutional framework of government with widespread suffrage. Both Pueblos are made up of several villages, and both border on Route 40 (formerly Route 66). Acoma's most traditional village has always been remote -- The Sky City -- but has for many years encouraged tourists to arrange to visit by pack horse, and is known for its colorful myths and pottery. Laguna has no such tourist attraction but does have industrially useful mineral deposits, more land, and more people. Laguna Pueblo also seems to have more ties with the University of New Mexico and with federal agencies as well as with Albuquerque business outlets.

Real questions can be raised about the effectiveness of community mental health work with these two rival populations by the same team on a fragmented schedule. However, these issues which are dramatized by the close location and tense interactions of these two pueblo groups, are perhaps only more visible manifestations of the problems faced in some of the other 26 populations to whom the Mental Health team must provide services.

IV. ROUNDING OUT PROGRAM DEVELOPMENT

A. Contract Care in the Mental Health Program

1. Inpatient and Alcoholism Services

In the fall of 1971 a request to describe unmet needs was met by preparing a description and rationale for services from the Mental Health Programs Branch. The documentation for services already being provided shows substantial use made of inpatient facilities both at the State Hospital and in alcohol treatment programs for detoxification and other specialized services. This document expresses the paradoxical fact that as more Mental Health Program staff are added by IHS there is a larger percentage of Indian patients identified who need specialized services, and consequently a need for contract care to be paid by IHS to inpatient facilities to supplement the outpatient and educational efforts of the program. Similar reports are available for succeeding years, and were possibly made in prior years. However, this 1971 document gives more details of the manner in which estimates are arrived at than any of those available so it is included here. Omitted are introductory paragraphs describing staff which would be redundant here.

1971 Report prepared by Albuquerque Area Office Mental Health Programs:

In addition to the mental health resources that have been added as members of the Mental Health Branch, PHS, several of the Indian communities which we serve have initiated alcoholism programs and most are involved in the CHR program. Both of these programs provide additional community resources with an interest in mental health within the community. As a result of these program expansions there has been, and in all probability will continue to be, a rather abrupt increase in the need for services which cannot currently be provided at the community level. The immediate effect of the growth in the mental health resources has been to record an increase in the number of problems in the field. In order to deal effectively with the number of these problems, it will be necessary to make more extensive use of contract facilities outside the PHS.

Concomitant with the increase in field personnel concerned with mental health problems, there has been a shift in many of the community attitudes about the use of such resources as New Mexico State Hospital, Bernalillo County Mental Health Center, Ft. Lyons Hospital, etc. At least part of the shift in attitudes may be attributed to the people working in the field. However, it should be noted that there have been some changes in program focus within some of these treatment facilities which may also have influenced the shift in attitudes. For example, the New Mexico State Hospital has over the past few years gradually developed their programs toward short-term hospitalization for crises situations rather than the custodial care associated with long-term hospitalization. In addition, specialty programs (e.g., alcoholism treatment) have been developed within this facility. It is within the context of these changes, and their implications, that we anticipate a continued expanding need for access to specialty treatment programs outside the current capacity of PHS-IHS.

I. New Mexico State Hospital

Contract Health Service monies allocated for use in state hospital facilities, including New Mexico State Hospital and Arizona State Hospital, are included in a separate contract care budget. Expenditures at these facilities for FY-72 are estimated at $68,000. However, a brief analysis of hospital usage within the Albuquerque Area, excluding the Navajo Area, and patient admissions to Arizona State Hospital indicate that in all probability we can anticipate a need for at least 44 hundred patient days at New Mexico State Hospital during FY-72. At the current approximate cost of $20 a day, a gross estimate for this amount of service would be $88,000. It should be emphasized that this figure is for the Albuquerque Area only and does not include admissions to New Mexico State Hospital or Arizona State Hospital from the Navajo Area.

The estimate of 4,400 patient days for FY-72 is based on a brief analysis of census and admissions during FY-71 and a comparison of census and admissions during the first quarters of FY-71 and FY-72. During FY-71, a total of 32 patients were hospitalized for 3,179 patient days or an average of approximately 100 days per patient over

the fiscal year. During the first quarter of FY-71, 12 patients were hospitalized for 767 patient days (average stay during this quarter was approximately 64 days per patient). During the first quarter of the current year, FY-72, 27 patients were hospitalized for 1,073 days (an average of approximately 39 days per patient). If we project an increase in length of average hospitalization for FY-72 that follows the increase from an average of 64 days per patient during the first quarter of FY-71 to an average of approximately 100 days per patient for the entire year, we would anticipate a need for approximately 4,400 patient days for FY-72. If we simply compare gross in admission figures and a number of patient days for these admissions over the same periods (i.e., first quarter FY-71 and first quarter of FY-72) we find an increase to date of approximately 125% in the number of patients admitted and approximately 40% in the number of patient days. This also projects to a need of approximately 4,400 patient days for FY-72. Both these estimates should be qualified as minimal needs, since they assume that the first quarter increase in the number of patients and in the total number of hospital days will hold constant (i.e., show no further increase) for the remainder of FY-72. As we have noted above, we feel there may be reason to anticipate a further increase in the number of hospitalizations at New Mexico State Hospital during the remainder of FY-72.

II. Other Contract Health Services

All other mental health services covered by contract health services are included within the GM&S services. These include alcoholic detoxification and treatment at Turquoise Lodge in Albuquerque, at Pecos Lodge in Roswell, at the Alcoholism Treatment Program in Albuquerque, and at the House of Hope in Salt Lake City, Utah; short-term hospitalization and limited out-patient care at Bernalillo Mental Health Center; specialized program care such as at theConvulsive Disorder Unit in Albuquerque, and limited psychological evaluation and testing. In addition to the projected needs for hospitalization at New Mexico State Hospital, we feel there will be an increased need for access to other specialty programs through contract health care. Three major programs currently being developed will influence both the quantity and quality of problems we can anticipate having to deal with over the coming years. These are the out-patient facility at the Albuquerque Indian Hospital, the opening of the Southwestern Indian Polytechnical Institute in Albuquerque and the development of Alcoholism Treatment Program within a number of the communities.

1. Albuquerque Indian Hospital out-patient clinic

Current projections of the patient load at this facility are estimated at 12,000 to 15,000 contacts per year. We estimate that at a minimum 3% of these contacts will be in need of some kind of mental health services. This means for 350 to 450 additional contacts per year that will be brought to our attention. Services for these cases will involve the range of mental health care from psychological or psychiatric evaluation and care through alcoholic detoxification and treatment to short-term hospitalization.

Approximately 300 patients X $150 average estimated cost: $45,000

2. Southwestern Indian Polytechnical Institute

Current estimates indicate that some 1400 students are expected to be enrolled by FY-74. Currently $20,000 have been requested to meet anticipated needs of the 700 students expected this coming year. By FY-73 this population will have nearly doubled, consequently we would anticipate a need for doubling the amount of monies needed to meet the mental health needs by this time.

$20,000

3. Alcohol Treatment Programs

With the development of alcoholism in the number of Indian communities, there has been an increase in the need for medical services to support these programs. Much of this has been the use of Turquoise Lodge for detoxification and initialization for the local programs. Some use was made of the alcoholism treatment program in Albuquerque during FY-71 which was not charged to PHS. Recent refinements in eligibility for servces at ATP have virtually eliminated this possibility during FY-72.

Estimating one person per month from each of the 26 Indian populations within the Area at an average cost of $175 per patient - Approximately: $55,000

III. Adequate Level of Services

In addition to the above noted programs and the monies needed to implement and sustain an adequate level of services as delineated through these programs there will be a growth in Mental Health field staff over the next two years. Additional monies will be needed to support and fully develop this aspect of the mental health programs within the Area.

1. Psychological Consultation, Evaluation and Testing

These include individual evaluations as an adjunct to consultant and/or coordinator involvement in one-to-one situations, specialized consultations and therapy (e.g., speech therapy, physical therapy, etc.), and contract services where it is appropriate.

Estimated cost: $5,000

2. Short Term (acute) Hospitalization

To fill the service gap between the State Hospital and out-patient counseling or consultation we should begin to make more appropriate and fuller use of existing facilities such as Bernalillo County Mental Health Center. Their records indicate that there is already a trend in this direction on the part of the Indian populations. With the development of the out-patient clinic at the Albuquerque Indian Hospital and the development of a mental health program within S.I.P.I., the number of referrals will undoubtedly increase. We can expect that the same will be true of the programs in the field.

$15,000

3. Specialty Clinics

These would include such developments as the use of an evaluative "team" from one of the existing programs within the state for pre-evaluation, evaluation and follow-up consultation around specialized problems, e.g., emotional problems as learning disabilities in school children. We are not currently making adequate or effective use of these resources to deal with the problems we are encountering.

$5,000

IV. Summary: Program needs over the next fiscal year are estimated as

State Hospitals	$88,000
Albuquerque Indian Hospital Out-Patient Clinic	$45,000
Southwestern Polytechnical Institute	$20,000
Alcoholism Treatment Programs	$55,000
Psychological Evaluations	$ 5,000
Short-Term In-Patient Care	$15,000
Specialty Clinics	$ 5,000
TOTAL:	$213,000

It should be noted that these estimates should not be taken as either purposefully including or excluding the estimates from the Service Unit Directors as to their perceptions of the needs within their Service Units. Much of what is proposed above is probably subsumed within their planning, and their delineations of the needs may be greater or lesser than outlined here. It is hoped that whatever monies that are allocated for mental health needs will not be apportioned from already existing contract health service budgets, but rather that additional monies, in line with the needs as stated by the Service Unit Directors and above, will be allocated to meet these needs at the Service Unit level.

2. Children's Programs

In addition to this use of contract funds to provide inpatient care for Indian persons requiring psychiatric treatment, other uses were made of contract funds by the Mental Health Branch. The use of a contract with the College of Santa Fe to provide stipends for students whose field work in Social Welfare involved the peer counseling program at St. Catherine's School has already been described, for instance.

The use of specialized resources for children, parallel with the inpatient facilities for adults, stimulated an evolving relationship with the Albuquerque Child Guidance Clinic for intensive work with and evaluation of individual children. This clinic began to assume an advocacy role, which it was much freer to adopt than the federal staff of IHS, and has established close working relationships with both the larger community of resources in Albuquerque and the IHS staff as a result.

Two individuals, Delores S. Butt, a psychologist, and Betty Jo Fairbanks, a speech therapist, have been available under contract for a limited number of evaluations of individual children. The speech therapist has worked almost exclusively with the Headstart program at Santo Domingo, providing a much needed level of expertise in the evaluation and development of individualized

plans for bi-lingual children. The psychologist has been utilized by the staff for evaluations and consultations around children and youth form a wide variety of locations. In both cases, the highly satisfactory outcomes of these contract consultations have led to not only increased acceptance by the Indian community, but an increasing request for services that threatens to swamp the personnel and financial resources available.

B. Staff is Completed: Dale Dodds, Ph.D., 1972—

In the fall of 1972 the need for psychological services to be provided by contract was still further reduced by the addition to the staff of Dale Dodds, Ph.D. Dr. Dodds had been on the faculty of a college in the Dallas-Fort Worth area, and chose to enter IHS service on a full-time basis. He made his home in Santa Fe, and assumed responsibility for the pueblos closely located around it, including San Juan, but not all of its associated 8 northern pueblos.

This program developed out of a period of extended cultural shock incurred in learning to move freely about the Indian communities and within the IHS bureaucracy as contrasted with academia. In general Dr. Dodd's pattern was most like that of Dr. Davis, composed of the same formal mixture of direct services and consultation activities to the communities assigned to him. He was also available to perform testing services for Dr. Davis or other staff seeing a patient caseload.

With the addition of Dr. Dodds in 1972 the organizationof work loads was again simplified. Dr. Davis remained chiefly involved at the two central hospitals, Santa Fe and Albuquerque, and spent approximately 80 percent of his time seeing patients. Mr. Hiatt and Miss Zynciewicz worked as a team in the central area of the state. Dr. Douglas spent approximately two thirds of his time between Mescalero and Jemez and San Felipe, with some consultation to other pueblos in the southern section. He also assumed responsibility for some of the details of budget planning and other aspects of administration.

C. Special Interest in Alcoholism Program Developments

Mr. Archibald found that his interests in alcoholism programs resonated to a felt need in the communities in which he worked, particularly at Taos and Dulce. In response to many community attempts to mount an alcoholism program in Taos he prepared a statement for the tribal alcoholism coordinator in Taos outlining what appeared to him the essential elements of a community program that had some chance of success. Since it not only inventories the components of a multifaceted program in the Taos community, but also includes some original suggestions concerning the philosophy of making such services available, it is quoted here in full. Readers should note that this is Mr. Archiblad's statement, and not all its points of view are shared by other Area staff.

> Alcoholism is a term used in Indian communities to encompass a multitude of psycho-social problems that are being run from by hiding in the bottle. It is generally agreed that the first task is to convince the person to stop drinking. This typically requires either (1) substitute escapes, or (2) solution, or at least easing of the environmental stresses that are interacting with the unique personality.
>
> A successful program must be (1) multi-facted, and (2) applicable to all. The first is the easier of the two, because what we already have and what we need are more easily identified. Essentially we now have several persons willing and able to offer counseling to the "suffering alcoholic" and several centers to send the habituated drinker for an intensive program of "rethinking." We lack a functioning:
>
> 1. Alcoholics Anonymous Group - Jerry Giron
> 2. Alanon Group - Lorencita Lujan and Florence Martinez
> 3. Alateen Group - Jimmy Cordova
> 4. Alcoholism Treatment Council (directly involved).
> 5. Committee of Concern (representing all concerned).
> 6. Alcohol Abuse Case File (to document progress).
> 7. Half-Way House - Paul Bernal
> 8. Alcohol Information and Drop-In Center
> 9. Volunteer Group of "friendly counselors."
>
> The list could go on, of course, but this would be more than the best program I have heard of has achieved to date. The Alcoholism Treatment Council should meet at least once a week to assess priorities, and the Committee of Concern should formally meet at least once a month for progress reports to be kept abreast of where they fit in.

"Applicable to all" has a nice ring, but there is a catch in it. To date we have not treated alcoholism with the seriousness "the No. 1 health problem in the Indian community" deserves. Specifically, we have left it up to the identified alcoholic whether he wants treatment. Typically he does not, and we have felt justified in saying, "Well, you can't force him to stop if he doesn't want to." Not so! For an illness of epidemic proportions, affecting and infecting all about the identified patient, we must intervene with the involuntary patient.

This will require the understanding and cooperation of the appropriate legal body: tribe, town, or county. The behavior of the intoxicated person brings him to the attention of the police officers. He is typically detained in jail initially. Now comes the crucial change in procedure. I would suggest a medical probation, the terms of which would be two-fold. Appearance each morning at one or more designated stations for Antabuse administration, and individual or group counseling geared to the needs and preference of the patient. It would be a "one day at a time" program in the AA philosophy, with failure to live up to the terms of the agreement without legitimate excuse met by instant re-incarceration. Ideally, the detention facility in time would not be the jail, but the Taos Alcoholism Treatment Center; in the meantime treatment would be brought into the jail. Indeterminate sentences would be best, but if this is not legally possible the patient's adverse behavior would earn him a new sentence.

This cannot be carried out without proper groundwork with all concerned, including all the citizens of Taos Pueblo. It may be reacted to initially as an infringement on the rights of the individual. This was probably true of TB or other contagious diseases at one time. The important point is that in either the acute or chronic stages of this illness, the patient cannot control his self-destructive drinking, and those who care for his welfare must make wiser decisions for him until he is capable of making them for himself. Otherwise progress in combating this pervasive problem will be minimal.

I have not stressed training in this structure, but it should be available as the cadre of helping persons increases. Confidentiality will be raised periodically as an excuse for non-coordination; knowing that in reality everyone knows of the patient's problem and could be nothing but delighted that he is getting help. Finally, we know that this crutch is no respecter of age, sex, or position, and all are entitled to the same concern supported by action.

I will be available in any way you see fit to carry out the goal of greater stability and responsibility for those who have chosen this unsuccessful coping mechanism to their disservice.

In late 73 and 74 this program had not been implemented, although some progress toward developing the multiple services as to be seen. The local Mental Health Coordinator engaged himself mainly in work with youth, including both recreational sports activities and training in traditional values allied with the Kiva. He felt strongly that these services would have a preventive effect impact.

At Dulce the Jicarilla Apache contacts for the work of Mr. Archibald seem to focus around the tribal alcoholism program and the tribal officials, including the courts. There was a frankly expressed felt need by many of the local Apache for the direct clinical services previously offered by Dr. Davis, even though he had not been a regular consultant to this reservation for about two years. At times the Mental Health Coordinator felt obliged to provide transportation to Santa Fe in order that an individual might visit Dr. Davis, as a supplement to locally based services. Mr. Archibald seemed aware of the resistence to the community-based appraoch, but was also committed to the idea that the total involvement of the community personnel was a prerequisite to the success of any program, and that therefore his task was to stimulate interest and to help clarify the matter of local responsibility as much as it might be to provide services.

Mr. Archibald did provide direct services of another type in the Albuquerque Area itself. The Bernalillo County Medical Center operated a comprehensive Community Mental Health Center, and Mr. Archibald served as consultant to the inpatient staff with regard to Indian patients. He also co-led a weekly group session of staff and inpatients at the facility, thus helping

to bridge the separations among patients and between staff and patients that often accumulate in an inpatient setting. This group included the Indian inpatients, but also the non-Indian patients and staff, since segregation and discrimination were not practiced by the center.

D. Current Developments at Mescalero and Jemez

Dr. Douglas divided the bulk of his time between Jemez Pueblo (where he and the University of New Mexico had hopes of a long-range project of exchanging services for field training experiences) and the Mescalero Apache Reservation to which he had access because of his ability to pilot a small plane.

A number of new projects developed with the Mescalero Apache. A youth program was developed out of community concern about the hazards of drug abuse. This program evolved into means of providing teenagers with ways of exploring alternatives to drugs and alcohol as methods of solving personal and social problems. Staff training and consultation and a series of community seminars sparked considerable community interest, and the consultant and Mental Health Coordinator played a significant role in this program in 1972.

These community programs and workshops led directly to the establishment of the Mescalero Apache Rehabilitation Center, which was a vehicle for the community based rehabilitation program expressly developed to deal appropriately and more adequately with problems of and associated with alcohol abuse. The Mental Health staff functions as consultants and advisors to this program, and in late 1973 facilitated the testing of a number of participants in order that vocational rehabilitation funds and services could be made available.

In addition, working through the CHR's at Mescalero a number of workshops for resource persons in a wide variety of agencies provided technical information about drugs available and the effects of misuse as well as some understanding of the problems of individuals who misuse them.

Perhaps one of the outstanding eventual long-range results of Dr. Douglas' work at Jemez will be the epidemiological studies presently being developed. Through cooperation with the State Technical Vocational School a data bank is being constructed which will eventually contain population statistics, court records, medical records, and school data about the entire population of the Area. Birth, death and accident records are being screened and accumulated as well. The resulting studies will enable not only the depiction of longitudinal epidemiological trends, but the delineation of problem areas within communities and the supporting information for planning more adequate comprehensive community services.

V. GENERAL OBSERVATIONS

At the end of another section polarization between the two psychiatrists was mentioned as a factor affecting the planning and development of the programs of Mental Health Services. By 1974 this polarization was not so clearly evident, but rather a range of viewpoints, personal commitments, and types of expertise existed among the staff. Dr. Davis and Dr. Dodds were most alike in pursuing a career of direct clinical services, although Dr. Dodds was able to add the technical tools of a psychologist. Both of these men, and to some extent Mr. Archibald who conceived of his service delivery in a different manner, seemed to feel strongly that they could not penetrate

the peculiar and different culture of the Indian world. Rather they felt that their services were most successful when engaged with those Indian people who were caught in the stresses of cultural transition, but whose goals and identification were allied with the majority culture--largely middle class and white Anglo-American.

Dr. Dodds, for instance, while correctly perceiving and labeling the behavior of the Mental Health Coordinators as "passive-aggressive, according to clinical standards", could not empathize with their distrust of projective tests. He had not yet had sufficient opportunity to understand Indian cultures and value systems to have insight into the manner in which otherwise apparently better-educated-than-average Indian men might equate the apparent mind-reading appects of the Rorschach with witchcraft and other Indian practices which were not discussable. Dr. Davis frankly felt that he could explore the possibility of referral to a traditional healer for patients who did not seem able to participate in his clinical offerings. Nevertheless he had little experience of the traditional healing as a parallel system. This spearateness is probably desired by the Pueblo peoples, many of whom are critical of the closer colleague relationships they observe among the Navajo.

Both of these staff members, together with Mr. Archibald, tended then to prefer to work with those whom they termed "apples"*, and to aid them in the transition toward the mainstream of US culture and activity. Dr. Davis certainly preferred verbal patients and maintained a diffidence about interference in Indian traditions. Mr. Archibald in particular focused much of his work with youngsters around groups which would help them develop the verbal facility to survive when

*"Red on the outside but white on the inside' -- a term variously used but probably self-explanatory.

they went away to school or work. He also developed training in English language usage for Mental Health Workers, both newly recruited and already in service, in order that they might make use of the training programs offered both at Desert Willow and at local colleges.

Mr. Hiatt and Miss Zynciewicz found ways of marketing their particular varieties of expertise which also capitalized on the stresses of transition between home and school, or between youth and the adult social world. They were also able to involve themselves within the total communities they served, through supporting the concrete realistic strengths of the persons with whom they came in contact. They did not see themselves as globally responsible for community or personal solutions, but were content to define specific regions of contact and work within them from the vantage of their respective disciplines.

Dr. Douglas, by implication had much more insight and empathy into the cultures of the communities with which he was involved, but the caution of a research orientation may have inhibited his sharing this. He did not discuss his approaches or convictions about therapy, but seemed willing and able to engage in it using interpreters or not, as was needed in individual cases. He also brought to bear on particular situations his areas of expertise and knowledge as a teacher or as a consultant, in a fairly contemporary fashion without any expression of need to aid a transition away from tradition. His respect for traditions is often implied, and his knowledge of them is greater than most of the other staff.

The strong note that held this staff together was an agreement that no one should impose their own beliefs on anyone else. This seemed to apply

at a variety of levels. Within the staff it meant that there was not a setting down of plans and agreeing upon them, and thereafter appraising each staff member's accountability in relation to these objectives. In relation to the communities, this was expressed in terms of response to requests, rather than initiating programs, with Mr. Archibald perhaps less inclined not to propose ideas and/or develop models with a "coercive" orientation. One sometimes felt that he considered that he often knew what was best for people, but had a hard time getting them to accept his ideas. The mode of business within the staff was almost an-hierarchical, and certainly quite in contrast to the expectations of other IHS branches and personnel. In some sense this may have been a reaction formation against the almost too rigid, slightly militaristic bureaucracy of IHS. Whatever its source it resulted in eventual alienation of most IHS staffs, especially at the Area level, and eroded support for many inservice training attempts at the central hospitals in Albuquerque and Santa Fe.

A. Description of Staff Consultation Activities

In 1973 the entire staff of the Albuquerque Area Mental Health Programs was asked to describe its work according to the various activities in which it engaged. Five of the 6 professional staff completed the questionnaire, and 9 of the 10 paraprofessional Mental Health Coordinators did so. Several comments can be made considering these self reports. For instance, two professionals and two Mental Health Coordinators reported that they never worked beyond the limits of the regular 8-5 work day, 5 days per week. One professional reported varying amounts of time, not counting travel time, spent during these hours.

One professional and 5 Mental Health Coordinators reported 10 or more hours spent in work traveling each week. Several of the Mental Health Coordinators noted that there was need for more than one paraprofessional person in each community if availability at times of crisis was desired, since individual and family crises seemed to occur with greatest frequency at nights and on holidays, and this meant a great deal of demand that could not be scheduled into a regular work schedule, and which tended after a period to infringe on the workers'own normal family living. In spite of these many overtime demands of the jobs, neither professionals nor paraprofessionals tended to ask for or receive compensatory time off for work-related activities outside the normally scheduled 40 hour week. A 50 hour week seemed modal for the Mental Health Coordinators; a 45 hour week for the professionals.

In estimating the division of this time among the major types of tasks there was more variation among the professionals than among the Mental Health Coordinators. As can be seen on the accompanying table (Table C), the professionals tended to spend about 10% of their time in administrative tasks and paper work and another 10% in teaching activities. One paraprofessional did not have any administrative time allotment, but most followed this same pattern, although some had more teaching or administrative time allotments. The paraprofessional group listed teaching activities including first aid courses, and sports instruction, and recreational activities for adolescents, and alcoholism courses for community persons. The professionals taught the paraprofessionals and others such courses as introduction to group psychotherapy and understanding disturbed children. They also taught inservice

programs for skilled persons such as nurses, and Social Service staffs, or in academic settings. There was no mention of any effort to teach Indian cultures, or community organization.

All the paraprofessionals themselves devoted a portion of their time (the mode being 30%) to learning as related to the job. Only two professionals were so occupied for any portion of their working assignment.

The bulk of the time, and the bulk of the interest for this report lies in the three tasks: direct clinical services, consultation with others about patients, and consultation about programs. The professionals ranged from 10-50% of their time spent in direct clinical services, and in a later interview the head of the Mental Health Program, Dr. Davis, reported that during these years he spent at least 80% of his time in direct clinical service delivery. Only 7 Mental Health Coordinators out of the 9 reported any direct clinical services, and this was 30% or less of their total time on the job. Consultation about patients occupied 20-30% of most professionals' time, although one indicates less than 10%. It occupies 10-20% of the paraprofessionals' time.

Consultation about programs in mental health took from 10-20% of all Mental Health Coordinators' time, and a range of from 10% to 40% of the professionals' time. A more detailed breakdown of the agencies with whom the staff consults, and whether or not they consult about patients, or programs is given in Table C. An additional column in this table indicates whether or not there were regularly scheduled (informal contracts) and/or formal contracts for these consultations.

TABLE C

Consultation by IHS Mental Health Staff
With Community Groups

Community Program or Group	BY PROFESSIONALS N=5			BY PARAPROFESSIONALS N=8		
	About Patients	About Programs	Regular Schedule	About Patients	About Programs	Regular Schedule
*IHS Physicians	5	5	1	8	3	0
IHS Nurses (Clinic)	5	5	1	5	1	0
IHS PHNs	5	5	1	7	4	1
Other IHS staff	3	5	1	3	4	0
Pvt. Drs & Clin.	4	3	0	3	0	0
State Hospitals	4	2	0	6	7	0
Community M.H.C.	4	2	0	2	1	0
Traditional Healers	0	0	0	6	1	0
Community Health Rep	4	3	1	5	3	2
Detoxification Units	2	1	0	6	3	0
Alcoholism counselors	4	3	0	8	8	1
Halfway House Staff	3	1	0	5	2	0
Local Bars	0	0	0	1	0	0
Public Schools	5	3	0	4	6	0
Parochial Schools	4	3	1	3	1	0
BIA Schools	5	4	0	5	5	1
Headstart Programs	5	4	0	6	4	2
Day Care Programs	1	2	0	0	0	1
BIA Social Service	3	2	0	7	6	2
Welfare Depts (State & County)	5	2	0	6	4	1
Vocational Rehab	3	3	1	4	3	0
Tribal Leaders	0	0	0	2	0	0
Tribal Courts	3	2	0	7	5	0
State/local Courts	0	0	0	4	2	0
Tribal Police	3	1	0	7	6	0
Local Police & Sheriffs	1	1	0	5	3	0
*+Jails	2	0	0	5	3	0

*To read this table the top line is interpreted as follows: 5 out of 5 professional MH staff consult IHS physicians about patients, and about programs, but only one has a regular appointment or "contract" to do so. 8 out of 8 paraprofessional MH staff consult IHS physicians about patients, 3 out of 8 about programs, and none have regular appointments to do so. *+ 2 out of 5 professionals consult with Jail personnel about patients, but none about program development and there are no regular appointments. 5 out of 8 paraprofessionals consult with Jail personnel about patients, 3 out of 8 about program development, but none have regular appointments to do either.

This table suggests a number of comments. All professionals on the Mental Health Programs staff consult with IHS physicians, nurses, public schools, Headstart programs and Welfare departments about patients, programs, or both. However, only one person has a 'regular appointment or the type of 'contract' for any one of these to do so, and not necessarily the same professional in each instance. All paraprofessionals consult with IHS physicians and with alcoholism program counselors, and all but one with other IHS staff, BIA Social Service, tribal leaders and tribal police, but again mainly without any regular schedule or any informal or formal contract. Only paraprofessionals consult with local courts, tribal leaders, or traditional healers. Omitting IHS consultations, the paraprofessionals have more consultations about programs with other community agencies by about two to one, and although neither group works by regular appointment, the paraprofessional seems more apt to do so than the professional.

In the case of tribal programs and traditional healing personnel, it would appear from this data, and from interviews and reports, that contact with these persons is one of the functions of the paraprofessional, rather than the professional. The professional tends to be slightly more involved with health professionals and parochial and BIA schools as a rule. However, these data are not adequate to make fine discriminations, and the degree of parallelism is more striking than any other differences not noted above.

B. 1974 -- Change of Command

In the spring of 1974 the lines of communication between the other Area office staff and the Mental Health Programs Branch became stretched to the breaking point. Dr. Davis accepted a transfer to the Cherokee Tribe of North Carolina, and Dr. Jack Ellis was transferred from Gallup to take his place as Chief of the program. Dr. Ellis comes into this setting with a combination of administrative experience in IHS settings, and clinical work on the Navajo Reservation that included operation of one of the two IHS inpatient services in the system. He has a style respectful of differences and an ability to coordinate complex staff patterns. He also has a reputation which makes him welcome and enables him to initiate fence building and mending of relationships within IHS. His task of leading this seven-year-old staff toward ability to articulate and operate within a framework of comprehensive vision of a total Mental Health Program will not be easy.

Some feel for the range and complexity of staff expertise and assignments can be garnered from a brief summary of 1974-75 staff assignments, excluding Area responsibilities:

Mr. Archibald - Psychiatric Social Worker - covers the region including the Consolidated Utes, the Jicarilla Apache, and the Pueblos of Taos, and Picuris. He works with two Mental Health Coordinators, one at Taos and one at Dulce on the Jicarilla Apache Reservation.

Dr. Dodd -- Clinical Psychologist - works with the Tewa-speaking Pueblos of San Juan, Santa Clara, San Ildefonso, Pojoaque, Nambe and Tesuque. There are Mental Health Coordinators at San Juan and at Santa Clara.

Dr. Douglas - Clinical Anthropologist - works with the Keresan-speaking

Pueblos of Santo Domingo, Cochiti, San Felipe, Santa Ana, and Zia as well as with Jemez. There are Mental Health Coordinators at Jemez and San Felipe.

Ms. Zynciewicz - Psychiatric Nurse - works with Acoma and Laguna communities, Isleta Pueblo and the Navajo population at Canoncito. Mental Health Coordinators are located at Acoma, Isleta, and Canoncito.

Mr. Albert Hiatt - Clinical Psychologist - is primary consultant at Zuni where there is a Mental Health Coordinator and the Navajo populations at Ramah and Alamo. He also covers the Albuquerque Indian School and serves as Branch Projects Officer, maintaining liaison with contract resources.

Dr. Jack Ellis - Psychiatrist - covers Mescalero Apache, where there is one Mental Health Coordinator, and the South Western Indian Polytechnic Institute as well, providing back-up services to all staff.

A report prepared in February 1975 describes the seven major activities of these staff as follows:

> In addition to these general areas of responsibilities, consultants and coordinators work with Indian Health Service hospitals, contract facilities and programs, tribal programs, other service agency programs, and other resource people in a consultative or collaborative capacity as required, or requested, and provide direct services to individuals whenever and wherever appropriate. While Mental Health staff are involved in a wide range of activities, these activities can usually be described in one or more of the following categories (excluding administrative and clerical duties).
>
> Proceeding from the more general and diffuse activities, in which the previous life experience and personality of the mental health worker, professional or nonprofessional, have greater importance, to the more specific, focused, professional activities:
>
> 1. <u>Getting acquainted and establishing trust and respect.</u>
>
> Includes both initial contacts with agencies, as well as later contacts, which need have no direct or specific program content, but do have implications, or potential, for programming and are,

in fact, a necessary preliminary to developing programs in areas with religious, political, socio-economic, or cross-agency sensitivity. Such contacts may be simply social in nature, but are nonetheless essential.

2. Becoming visible or maintaining visibility as a resource person.

These are activities which involve more or less brief contacts with agencies, organizations, community representatives and groups, or other workers to maintain an expectation of reliability as a resource person.

3. Facilitating or developing interagency communication, referrals, and coordination of resources.

Involves taking the initiative in making such a network effective, often playing a catalytic role.

4. Conducting case consultation.

Involves the provision of indirect services by assisting other service-providers in their provision of direct services.

5. Providing mental health information.

Conducting education and training sessions with various groups, e.g., teachers or counselors, nurses, medics, etc.

6. Helping develop mental health or mental health-related programs and facilities.

Involves activities which include assisting via meetings, committees, etc., in planning, organizing, developing, stabilizing mental health or mental health-related programs, e.g., working with non-IHS alcoholism programs, treatment centers for handicapped, special education facilities, etc.

7. Providing direct patient care.

Mental health workers are expected not just to assist, but to take charge with as full responsibility as necessary and possible, of patients considered mentally ill or emotionally upset, of any degree of difficulty or complexity. While this is especially true in a hospital setting, it is also the case in the field, where a mental health worker is expected to take the primary responsibility for getting such a patient into a hospital if necessary. In crisis situations, the mental health service is perceived as a medical service and cannot evade medical responsibility.

On March 17, 1975 Dr. Ellis forwarded to IHS Mental Health Programs Headquarters a summary description of the Albuquerque Area Mental Health Program as he and his staff see it nine months after he became Chief. The report is quoted in its entirety below as a fitting conclusion to the historical narrative portion of this report.

> Until this fiscal year, the Albuquerque Area Mental Health Branch has operated with two primary organizational foci, the Indian communities and the Area Office, with paraprofessional mental health technicians in the communities interacting with a multi-disciplinary team of professional mental health consultants operating out of the Area Office: a psychiatrist, a psychologist, a mental health nurse, and a clinical anthropologist. This year a change is underway to supplement the Area Office team by assigning a professional consultant to each of the four service units in the area. This person will be either a psychologist or psychiatric social worker, generally. With such an organizational structure, working within the comprehensive IHS health program and supplemented by such other resources as exist or can be developed in the area, the Albuquerque Area Mental Health Branch attempts to approach the goal of providing a comprehensive community mental health service for the 36,000 or more American Indians residing in this area, in the cities of Albuquerque and Santa Fe and in twenty six reservation or tribal communities served by the four Albuquerque Area Service Units.
>
> Since 1966 the Mental Health Branch staff has grown from one psychiatrist to a current staff of twenty one. This includes seven professional positions, twelve mental health technician positions and two secretaries. Each professional consultant is responsible for a geographical area encompassing several tribal reservations, while each mental health technician is resident within and a member of a single reservation community. Since there are twenty six reservations in the Albuquerque Area, it is apparent that more than half are without the services of a mental health technician, while each consultant must attempt to provide services to as many as six reservations, with distinct cultures and often different languages.
>
> Because of the nature and distribution of the Albuquerque Area Indian populations, it would be desirable eventually to place a mental health technician with each tribe, since even when adjoining tribes speak identical languages, their cultures and social organizations are so different as to render a technician from one tribe ineffective in the other. Since some of the tribes in the area are too small to justify such a placement, a goal of eighteen mental health technicians, one for each tribe of 500 or more population, appears more realistic, backed up by nine consultants, one for every two technicians.

It must be borne in mind that community mental health workers, both consultants and technicians, must spend about half or more of their time in the following essential non-patient care activity categories:

1. Making contacts and establishing relationships with a wide range of agencies and individuals involved in and with the communities served.

2. Maintaining regularity and visibility as a resource person.

3. Facilitating or developing inter-agency communication, and coordination of resources.

4. Providing mental health information and education.

5. Helping develop community mental health or mental health-related programs and facilities.

6. Providing mental health consultation.

The seventh category of community mental health service activity is direct patient care. This is a high priority category of course, but even if we had adequate staff to provide direct patient care whenever needed, for all age groups and social problems, we encounter so many individuals and problems requiring multiagency and multidisciplinary input, at all levels of government, that the need is inescapable to expend much or most of our time and energy in the first six categories.

With this in mind, the Albuquerque Area Mental Health Branch may be characterized with reference to several of the above categories, as follows:

1. Making contacts and establishing relationships.- Recently a list was drawn up of agencies with which our staff believes it necessary to maintain some degree of continuing relationship. Its length may suggest the time necessary for this activity.

   a. Health agencies:

      PHS Hospitals and Clinics

      VA Hospitals

      Bernalillo County Medical Center

      Bernalillo County Mental Health Center

      Programs for Children

      Department of Hospitals and Institutions

b. State Commission on Alcoholism and its treatment facilities.

c. Private hospitals.

d. Municipal health agencies.

e. Kirtland Air Force Base Hospital

f. Contract facilities:

Private physicians and psychologists

Albuquerque Child Guidance Center

UNM Communications Disorder Unit

g. Educational institutions:

College of Santa Fe

University of New Mexico

Southwestern Indian Polytechnic Institute

Institute of American Indian Arts

BIA schools and dormitories

Parochial schools

Public schools

Headstart programs

h. Governmental agencies:

Division of Vocational Rehabilitation

Health & Social Services Department

Law enforcement agencies

State Department of Education

U. S. Forest Service

BIA

Office of Indian Childrens Services

i. Tribal programs:

Community Action Programs

Day Care Programs

Tribal Alcoholism Programs

Emergency Food and Medical Assistance

Police and Judicial departments

Community Health Representative programs

Maternal and Child Health programs

Tribal councils and committees

j. Miscellaneous

Half-way houses

Rehabilitation Centers

Native practitioners

3. Facilitating or developing inter-agency communication, and coordination of resources - The following is an example of an individual patient whose case appeared hopeless initially, in terms of direct patient care, but has changed dramatically as a result of sustained, long-drawn-out efforts to facilitate and coordinate resources:

A young man from a pueblo community, handicapped by epilepsy, severe disfiguring facial burn scars, alcoholism, poverty, lack of job skills, and an explosive personality, had become an unmanageable burden to his family and community, after attempts at custodial placement had failed because of his threatening emotional instability. The Mental Health technician from his community and his consultant began talks with all available local and remote resources, involving custodial homes, local alcoholism programs, district attorney, state hospital, Albuquerque Indian Hospital, Gallup Indian Medical Center, and an alcoholism program in Gallup. After many telephone calls and several conferences, a multi-agency, multi-disciplinary rehabilitation plan

was evolved, projected over months or even years into the future. The patient is now into his second month in the program and is optimistic for the first time in years. Much effort and expense for only one individual, as is the case with artificial kidney patients; but in the process a network of resources is evolved and cemented, experience is gained to benefit future patients.

4. Providing mental health information and education - Prevention is an important public health function, and formal information and education programs in mental health for patients and concerned family members and community citizens as well as for a wide range of other individuals and agencies can do much both to introduce remedical approaches and to make it easier to seek and find mental health services when early signs of disturbance are noted. At least one of our professional staff spends about 50% of his time in this activity.

5. Helping develop community mental health or mental health-related programs and facilities - We are currently using programatic services under contracts initiated in FY - 74 using add-on monies. Most of these contracted services will carry through FY - 75. These contracts include the following:

Albuquerque Child Guidance Center: $12,000

Evaluative, diagnostic, therapeutic, and consultory services. Mental Health staff make extensive use of this facility's services in all areas. In fact there is some reason to believe that if the contract is not expanded, use is going to have to be reduced. We would prefer for this contract to be reviewed, expanded, and regularily included in the Contract Health Service package at the Area level. During a recent five month period, 436 hours of services were provided in evaluation and therapy of Indian children.

College of Santa Fe: $3,000

Consultative, educational and evaluative services at St. Catherine's Indian Boarding School in Santa Fe.

Psycho-educational evaluative services: $3,000

Overused, especially as special education programs continue to be developed within various Indian communities. Dr. Butt has indicated that she may not be able to continue providing these services due to increasing workload. An alternate resource will be mandatory.

Speech and Language Program at Santo Domingo Headstart: $2,500

This program, although somewhat limited in scope, has been enthusiastically received by both students, parents and staff at Santo Domingo Headstart. We would like to renew this contract, perhaps in an expanded program. It may serve as a prototype for similar services in other programs as well, dealing with language handicaps and their mental health consequences.

Psychological Evaluations: $5,000

We have used a number of individuals to do psychological evaluations on an "as needed" basis. These generally are situations which either are outside the regular scope of the services noted above, or such that scheduling and travel factors make it more feasable to use other resources. Estimated costs for FY-75 to continue this procedure is approximately $5,000. At least thirty such evaluations were required in FY-74, all of school age children.

The following are some examples of cooperative efforts in which Mental Health staff were involved, either as prime movers, as resource persons, or as consultants, which have resulted in the establishment of specialized programs. All are examples which involved a collaborative effort with tribal officials, locally interested persons, Indian Health Service staff, and other agency representatives. (See following page)

Mescalero Apache Rehabilitation Center (MARC).

A community-based and operated alcohol treatment program at Mescalero. This program, organized around a residential treatment center, is housed in a facility adjacent to the IHS Hospital and serves as a combination crisis center, treatment program, and halfway house. Funded by NIAAA in 1972, the facility has been used by approximately 150 patients per year. It is a tribally organized, staffed and based program, which serves as a focal point for articulation with a variety of other treatment resources, both on and off the reservation.

Special Education Projects.

Mental Health staff have been involved in several communities in the development of locally-based programs to meet special educational needs of children. In San Felipe, and later in Jemez, the tribe provided the facility, a self-contained classroom, and the BIA provided the equipment, materials and staff. IHS and other agency personnel who worked in the community collaborated in the screening, evaluation and follow-up. In Zuni, Mental Health staff worked with tribal officials, local resource people and the McKinley County Public Schools System in developing two classes for educable children. This effort involved preliminary screening, home visits, follow-up evaluations, and programming based on the defined needs of the students.

Zuni Suicide Register.

The Mental Health Coordinator at Zuni, in collaboration with tribal officials, local law enforcement agencies, IHS personnel and other concerned agency representatives, has developed an on-going study of suicide. The project covers the period from 1965 to present, and has served as a useful data base for a variety of programming endeavors.

St. Catherine's Indian School Project.

As a result of consultations with staff at St. Catherine's, an attempt to develop a comprehensive mental health program within this parochial boarding school, located in Santa Fe, was initiated. A contract was developed with the College of Santa Fe to provide selected services to the school, and the Mental Health staff have been involved in a variety of roles in this project.

7. Direct patient care - During calendar year 1974, the Social Service & Mental Health Report data indicate 3035 patient contacts representing over a thousand patients seen by the Albuquerque Area mental health staff. Over 75% of these contact reports list individual problems (38%), problems of children and youth (13%), family services (8%), and alcohol problems (19%) as primary problems. If the data included those contacts where alcohol problems were listed as a secondary problem, we estimate that about 75% of the contacts would show a relationship to alcohol problems.

What the data do not show is the amount of time expending in making many of these contacts in the field, the missed appointments, the telephone calls, discussions and consultations with others working on the same case or with family members. There are few fifty-minute hours in Indian mental health practice and few patients are seen in the therapist's office.

The data also do not indicate time spent visiting about fifty schools and dormitories with some degree of regularity, from weekly or monthly to whenever called up, and making patient care services or referrals available thus to about 16,000 school age children.

Jack Ellis, M.D.
Chief, Area Mental Health Branch
Albuquerque Area IHS

bc: file - PROG PLANNING/MHB
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C. Problems Yet to be Resolved

As of the time of preparation of this report, there was neither time nor opportunity to assess the effects of the change of Chief administrative head of the Program. Therefore, some of the comments which follow may need modification or updating in the near future. However, both problems and accomplishments have roots deep in the total life of the program and could not be presumed to have diminished in the space of less than a year.

1. The relationships within the staff, while coated with mutual respect, do not allow for cohesiveness of planning, division of labor, or any ability to reach an agreement about a compromise in developing policy. The basic problem may not be which is right -- a community and consultation emphasis or a clinical direct services program. Perhaps the total program calls for both integrated into comprehensive services which provide means of linking with other resources without simply passing responsibility over to them for whatever elements a particular staff member or team may lack. Some means of escaping the either/ or polarity needs to be found.

2. After seven years there are still no statistics available concerning caseloads, modal problems of the various communities, or other baseline data for program planning. Once the 200 mark had been reached, no further mention of clinical contacts or caseloads appeared in the monthly and annual reports. No analysis of data otherwise available concerning the population growth rates, or the other possible epidemiological issues of the many varied communities appears to have been developed or utilized by any of the staff members. If it is being used it was never reported.

The present use of the computerized recording form for case contacts may fill this gap in 1974, by feeding back to the Area level some overall picture of staff activities of a clinical nature, and some definition of the most prevalent problems brought to IHS for assistance and resolution.

3. Although some ideas about "humanizing" IHS delivery of medical services is part of the initial motivation for developing the program, there seems to be alienation of IHS staff at all levels. This is not only true of relationships with hospital staff, but in relationships between Mental Health and Social Services branches. Perhaps the fact that the Social Services branch pre-existed Mental Health, and carries in its program mandate a responsibility for community and agency coordination contributes to this problem. Perhaps the laise faire administration of the first Mental Health Chief not only frustrated the social work staff when joint meetings were held, but also prevented negotiations of policy which would facilitate joint efforts.

4. A fairly large proportion of the Indian population of the Area has a view of IHS which tends to brand it in many of its relationships as racist -- even though it may not be expressed in these terms. To some extent this may be due to the failure of IHS in this Area to particularize its services, so that Service Units are equated with hospitals at some distance from most of the populations. (The exceptions would be Mescalero and Zuni, which might be an interesting test of the hypothesis.) To some extent the tendency of this staff to choose to work mainly with persons who want or are able to move toward the mainstream, and who therefore are most like the white staff, may be a reaction to this attitude on the part of the Indian. What is not clear is whether the staff intends to settle for this definition of themselves, or merely feels helpless to change it.

In all fairness, it must also be considered that the definite drawing of boundaries by the Pueblo groups, and a long heritage of interaction with the major culture colors local attitudes with more than a surface attitude toward outsiders.

5. Step by step planning toward common objectives would also facilitate orientation programs for new personnel that would prepare them for work with Indian populations in general, as well as specific communities. At the present time neither within Mental Health, nor as provision for new IHS staff is there any coherent orientation program designed to alleviate cultural shock, or identify areas of common concern.

6. The other issues which plague the Area Mental Health staff could probably be resolved, once the means to effectively decide policy and roles is established. Examples are the relationship of this program to alcoholism programs, to tribal courts and police, and toward the complex problem of responsibility for community organization including active efforts toward economic and social change.

D. Accomplishments

1. Where in 1967 there was a single staff member, in 1974 there is a staff of 21 -- seven professionals and two supporting clerical staff at the Area office level, and there are approximately 12 Community Mental Health Coordinators located in their home communities.

2. The difficulties of trying to relate to 26 communities have been faced, and to some extent solved by assigning definite geographic territories to each of the professionals, with assistance to each from indigenous para-professionals in a continuous training program. One professional lives in Taos, and thus is accessable to the extreme northern communities. Another, living in Santa Fe is available to the central communities and to facilitate within Santa Fe itself. The judicious use of the plane and automobile for travel enables the staff to meet weekly, yet maintain a dispersion of attention and effort which allows each community to receive focused attention.

3. Significant programs have been developed in a number of communities where the expertise of the staff fit the expression of local needs. Especially noteworthy are the consultative programs involving Headstart and Follow Through, and the consultations and services delivered to St. Catherine's Parochial School.

4. There has been significantly little turnover of professional staff, and relatively little turnover in the paraprofessional level. The two professionals who have left this particular program, both psychiatrists, continue to be active staff of IHS in other capacities or locations.

5. One staff member, Mr. Archibald, has received national recognition as a professional and serves on the Board of Directors of the American Orthopsychiatric Association.

6. Having two psychologists on the Area Office Mental Health staff has not obviated the need for some contract monies for psychological testing. This is still arranged in individual cases through the Albuquerque Child Guidance Clinic and the resulting supportive consultations by IHS staff have resulted in this clinic taking an an advisory role in recruiting services for exceptional children and youth of Indian descent within their catchment area or seen on contract through IHS. The mutual strengthening of services to both agencies is striking, and the benefits for the Indian community are quite evident.